

TRIANNUAL

AIRDROP REVIEW AND

MALFUNCTION/SAFETY ANALYSIS



PREPARED BY
THE US ARMY QUARTERMASTER SCHOOL
FORT LEE, VIRGINIA 23801-1502

AIRBORNE CREED

I am an Airborne trooper! A paratrooper!

I jump by parachute from any plane in flight. I volunteered to do it, knowing well the hazards of my choice.

I serve in a mighty Airborne Force—famed for deeds in war—renowned for readiness in peace. It is my pledge to uphold its honor and prestige in all I am—in all I do.

I am an elite trooper—a sky trooper—a shock trooper a spearhead trooper. I blaze the way to far-flung goals behind, before, above the foe's front line.

I know that I may have to fight without support for days on end. Therefore, I keep mind and body always fit to do my part in any airborne task. I am self-reliant and unafraid. I shoot true, and march fast and far. I fight hard and excel in every art and artifice of war.

I never fail a fellow trooper. I cherish as a sacred trust the lives of men with whom I serve. Leaders have my fullest loyalty, and those I lead never find me lacking.

I have pride in the Airborne! I never let it down!

In peace, I do not shirk the dullest duty nor protest the toughest training. My weapons and equipment are always combat ready. I am neat of dress—military in courtesy—proper in conduct and behavior.

In battle, I fear no foe's ability, nor underestimate his prowess, power and guile. I fight him with all my might and skill—ever alert to evade capture or escape a trap. I never surrender, though I be the last.

My goal in peace or war is to succeed in any mission of the day—or die, if needs be, in the try.

I belong to a proud and glorious team—the Airborne, the Army, my Country. I am its chosen pride to fight where others may not go—to serve them well until the final victory.

I am a trooper of the sky! I am my Nation's best! In peace and war I never fail. Anywhere, anytime, in anything— I am AIRBORNE!

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TAR&M/SA VOL III

PREFACE

The Airdrop Review and Malfunction/Safety Analysis is published by the US Army Quartermaster School in hopes that by "passing the word" the malfunction rate within the Armed Forces may be minimized. The review and analysis in this issue covers the period 1 September 2000 - 31 December 2000.

POC AND MAILING ADDRESS

The POC for Airdrop Malfunction Reports, Monthly Airdrop Summary Reports, and any other information concerning the Airdrop Review and Malfunction/Safety Analysis is Mr. Roger Hale. All correspondence for the above reports and analysis should be addressed to:

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REPORTS AND ANALYSES

The Malfunction/Safety Review Board met at Fort Lee, Virginia on 21 - 22 February 2001. A breakdown of the areas in which malfunctions occurred from 1 September through 31 December 2000 follows:

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45
24

All DD Forms 1748-2 (Airdrop Malfunction Report (Personnel-Cargo)) are reviewed, and any identifying information is removed. Block 24 is annotated to include both Army and Air Force references if only one is given. No grammatical editing is done to the reports.

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PERSONNEL MALFUNCTION REPORTS AND ANALYSES

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WHAT WAS THE MALFUNCTION?

Right risers caught under reserve.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Weak body position upon exit.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Centralized training team (MTT) that standardizes exact performance of procedures.

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WHAT WAS THE MALFUNCTION?

Incident - sprained left ankle.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper landing - feet apart.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Reinforce training standards.

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WHAT WAS THE MALFUNCTION?

Incident - broken bone.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper landing - failed to steer away and perform proper PLF.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Reinforce training standards.

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32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The only explanation for the cause of this malfunction that can be offiered is that when the jumper exited the aircraft, the deployment bag came off his back and began the rapid deployment sequence, once the two curved main container locking pins opened the main container, the black outer deployment bag with the green inner deployment bag still inside shot to the inside top of the C-130 ramp clam shell (as normally happens prior to the inner deployment coming out of the outer deployment bag), and during the split second spun or flipped through itself as soon as the inner deployment bag came out of the outer deployment bag while it was in the uneven, turbulent dead airspace immediately behind the aircraft in such a way as to cause the described riser inversion. The subsequent minor malfunctions were due to this initial suspected deployment abnormally. The parachute was not recovered due to the 13 kilometer distance between the release point and the drop zone.

ANALYSIS: 4

WHAT WAS THE MALFUNCTION?

Hung slider.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Jumper inexperience with possible tension knot.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reinforce training objectives.

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WHAT WAS THE MALFUNCTION?

Pilot parachute hesitation.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Possible coil lock in pilot parachute spring.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Reinforce packing inspection procedures.

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32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.) Cause of main canopy malfunction is unknown. Believe reserve malfunction due to poor body position after cut-away.											
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WHAT WAS THE MALFUNCTION?

Pilot parachute over nose followed by jumper entanglement with reserve.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Poor body position for reserve activation or possible out of sequence activation.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reinforce training.

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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

While conducting a 25,000 feet MSL high altitude high opening (HAHO) jump, the jumper experienced a broken left control line. This malfunction was compounded when the jumper reached for his main ripcord handling following the standard 10 second delay and inadvertently grabbed his low pressure delivery hose on his MBU-12/P oxygen mask and pulled the low pressure delivery hose away from both the hard shell mask AND the quick disconnect from the Airox VIII.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The suspected cause of the broken left control line is the hard opening shock upon deployment of the main parachute at approximately 23,500 feet MSL. The control line broke at the point where the toggle thong enters the finger trapped loop. Both "legs" on the finger trapped loop snapped; this is the weakest point in the steering lines. This type of malfunction has been seen on several occassions in the past, and occurs because the steering lines when set at 50 percent brakes during the packing procedure absorb the majority of the opening shock because they are attached to the back of the canopy where the pressurized air is forced to immediately stop upon opening shock, causing a snap of both steering lines due to the pressurizing airs inability to "escape" from the cells. The pressure and friction of the two legs of the finger trapped loop when the steering line toggle thong is set, slamming up against the lower control line guide ring causes

CONTINUED ON NEXT PAGE

32. CAUSE OF MALFUNCTION/FAILURE (continued)

causes friction resulting in the gradual breakdown of the steering lines at that point, this can be seen as the steering lines gradually become more blackened where they touch the lower control line guide ring. The problem with the jumper pulling the oxygen mask from his face has occurred on several occassions in the past but has gone largely unreported until stricter guidelines set forth are established requiring that any unusual occurrence during a jump be reported. Regarding this point the jumper states "At that point I realized I wasn't getting sufficient oxygen and my vision was getting fuzzy (hypoxia). Tracing the 02 hose from the end that plugs into the face mask to the end that goes into the Airox VIII, I brought both ends of the hose up to my face due to my lack of vision and saw that the hose was completely disconnected. I tried to reconnect the hose into the Airox VIII but it was jammed under my rucksack and extensive exposed LBE and was unable to get it loose. Although the gloves are thick they must continue to be worn for protection from cold or risk hypothermia and the inability to operate a weapons system upon landing. Recommend that other gloves with equivalent or better protection be researched and used to avoid this frequently occurring problem for units that conduct jumps from 24,999 feet and higher on a regular basis. This problem could result in DCS, hypoxia, off drop zone landings, mid air entanglements upon unconsciousness or injury upon landing.

ANALYSIS: 7

WHAT WAS THE MALFUNCTION?

Broken left control line.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Unstable pull causing uneven load.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- 1. Reinforce training where jumper traces cable housing down.
- 2. Possible relook at gloves with better dexterity level.
- 3. Use goggles that allow complete field of vision to visually confirm pull.

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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

While conducting his sixth MC-5 static line HAHO jump during the transition package (jumper previously transitioned to 25,000), jumper experienced a tension knot in the right steering line. In addition to the MC-5 SLDRAPS, the jumper was wearing a large ALICE pack rigged with HSPR and twin 53 portable bailout oxygen system. No weapon was worn.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Jumper has consitently shown excellent body positions upon exit since his initial transition training to the MC-5 SLDRAPS over one year ago and there is no reason to suspect that this night jump was different. Upon opening shock of the parachute, the jumper began a right turn. The jumper released both brakes and conducted a controllability check and discovered it was necessary to pull the left steering line down to approximately 75 percent brakes in order to continue straight line flight. The jumper stated that in the 90 percent illumination on this night jump he could clearly see that it was the right steering line alone that had a classic tension knot loop in it which was about 6-12 inches long. Jumper decided to cutaway the main parachute at approximately 20,000 feet AGL. The reserve functioned without incident. The cause of this malfunction a loop forming in the steering line upon deployment.

CONTINUED ON NEXT PAGE

WHAT WAS THE MALFUNCTION?

Tension knot right steering line.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper packing with possible line dump.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Enforce proper packing procedures with good line tension and quality assurance supervision.

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l.						(ÉÑAL							
1. ONLY BEING WALL TED			J. DEPARTUI	H A I	II IELG		3. L	IAIE		WPE ALE I		ACIT SE MD	
									Ļ	Casa 21			
E. OPERATION EXERCISE					1 02 440 40	ЖАПОМ	A DATE AND THE						
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14. HAPPE GARDEN TO SEE AND LON		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	. .	ľ			m.,	•	ľ		st pass/		
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17 THE PARACHUSE	4			_		MBLFLN(_			IS NO JUMPS	
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		HIOTE		Г	BLUMW NC	-	+	BACK IN SUSPEN		-		FF: 295	
MC-4	'	1						SIGN LINE			Twists/ Slider	S/L: 50	
21. IYM CH RESERVE	1.		CNC (KIN)		as Nesuci	NG HIUNY	_			• 1 TUIIS	Siluci	2,2,00	
		ED PROPE											
1(p-31)													
MC-4	<u> </u>	۲ لکا	ts 🔲	Nij				None					
						- 2							
Due to zero visib his viewpoint on parachute was re still halfway up to damage or defect during pull seque	ility the cov owa	y (nigh e surfact wered wered the ard the	nt), malf ce to ma with the e stabiliz	unc ke bra zers	tion NCC an accurat kes unsto . The enti tion. Poss	could to assure the assure owed, correction to the care of the car	not nptana ana chuse	t see the jurn tion for caus opy out of d ute system v could be an	npe se d lep	r clearl of the n loyme PIS Ju	nalfunc nt bag, ın 95 w	tion. Main and slider ith no	
			CO	NT	INUED	ON NE	EΧ	T PAGE					

WHAT WAS THE MALFUNCTION?

Line twists - hung slider.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

 $\label{thm:personal} Violation of FM\,31-19/AFI\,11-411. \ No \ personal \ oxygen \ system \ could \ have \ contributed to \ unstable \ body \ position.$

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Follow established procedures. Quality control supervision.

1				_	GENERAL								
I. 1. ONIT BEING WALLISTED		J. DEPART	IRŁ A	RII		3.1	IAIE F	4 1	MPE ALET		ACIT SET NO		
								Casa 212					
S. OPERATION EXERCISE				7	1 OZ AAD VOCATION	_		ì	A DATE P				
				İ									
S. ALF * ALTITUUS (Feel)	10	ALUT STEEL (Anols)	Т	יו	GE BLEVATION (Feet)		12 SUNFACE WARD	S M	noty	IJ VOBI.	HY (Pann M-Yer)		
12,500 AGL	ı	110 Knots			490 Feet MS	L	03 Kno	ots		Unl	imited		
4	_		_		PERSONNE								
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FF2/Altimeter/MC-4/02/													
Ruck/Weapon 1st Pass/3rd													
17 Také kapaggapasé (Specify)	٠,				Pythi mangilyan	(Topi	1				IS NO JUMES		
racent /1		SEMINASES KIN'	L	I	ANY PS ON CHARLETTE MOLL				DIRENT	PERM]		
		NI OL CHOLE			BLOWN MCT ON		BACK I 4 SUSAEH						
MC-4	L		L	T		\perp	SIGN LINE				210		
28. TYPE OF RESERVE	1.	RESERVE FUNCTIONS ED PROPERLY (M			AT RESIDE DING MICH	•							
	1	"No" explain m dom 31h			I								
MC-4		YES) w:		I		Non	ie					
32. CAUSE OF MALI Ater performing was found. Jump inspection of the of the malfunction	a 1 er f	CTION/FAILURI 00 percent infailed to perfo	E (If spe rm e bi	m cti a j	ore space is need on on the MC- proper controll kes were found	ed, 4 p	continue on r parachute sys lity check. I still be prop	eve ste	erse.) m, no c	deficie	ncy e use		
		CO	N]	ΓI	NUED ON N	EΧ	T PAGE						

WHAT WAS THE MALFUNCTION?

Pilot parachute hesitation.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- Cutaway based on jumpers belief of system failure.
 Not following proper procedures.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reinforce training to ensure confidence.

I.					GENERAL							
CONTRESS AND 150		J. DEPARIT	IRŁ A	FILE		ľ	UAIE		CH-46		ACIT SE • ND	
i. Operation exercise				Ī	1 OZ A40 vOCATION	_		Ĭ	A DATE A	ND TME		
S. ALAT ALTITUDE (Page)	10	ALAF SPESS (Anols)	T	ו יו	(I BLEVATION (FIRST		TE SURFACE WHID		n z tŲ	ı	IIY (FashM-Yar)	
10,000	L	90 KIAS			370 MSL	_	6 Knot	ts		Un	limited	
4			_		PERSONNE	_		_				
14. NAME Mast. Cras. MA CA	MDE.	. > 54H. & UN'I		M	ilitary Tander ithout Equipm	ı P	assenger	ľ	a JC WPE	4th	,14 62.	
17 TO BE PARACHUSE	4				FYPE MANIFUM						IS NO JUMPS	
(Seecify)		SEMITHYER/KIN'	Г	Γ	ayor inside	Π	(որգայի Մե տոլե		DIREN	JPECH YI]	
MTVS-421		HI OF CHOFE	Γ	Γ	erculus McLink		BAGKIN SUSAEN SIGN LINE				FF: 1500 SL: 50/6	
28. TYPE CH RESERVE	1.	RESERVE FUNCTION ED PROPENEN AV "No" septem m			as Nesuching Michigan	γ						
MTVS-421R												
				=								
32. CAUSE OF MALE Video shows that was reaching out operation and had	wł wit	nile landing or th his legs. SN	n ju IM	mp wa	pers 1 and 2 so as instructed o	eco n p	ond tandem ju proper landing	ım g p	p of th	ures pr	ior to the	
								•				
		CO	NT	ΓIΓ	NUED ON N	EX	XT PAGE					

WHAT WAS THE MALFUNCTION?

Incident - ankle fracture.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper PLF.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Reinforce proper training.

l.				- 1		GENERAL					1.			
1. ONLY BEING WALLESED			J. DEPARTU	INC A RITELLY				UAIE :	L	TYPEALL I	l,	ACIT SE • ND		
S. OPERATION EXERCISE				1 TO CAMP NOCATION						C-130				
K OFFICE IN EXERCISE											-D ME			
				_	_									
S. ALAT ALTITUDE (Feel)	10		(clor N) US	ď	٠ ن	CELEVATION (FMI)		JE PPHINCE ANNI	05/4	lusty.	ı	IIY (PashM-Yai)		
7800 AGL	_	12	25	_		230		<u> 5</u>			Unı	estricted		
4				_		PERSONNE			_					
14. BAME Mast. From MM G	MDE.	534H. &	GM-I	ľ	> 60	OPPINI WORKEY I	UMP	t•	١	IQ TO MESK	S POSITION	HIM ALFI		
				-	N.	ot Given			١		1			
	_			_	1				_		1			
17 To be baseached 16 (Specify)	<u>.</u>	_		_	_	FYM; MINIFUN	(1-0			_		13 NO JUMPS		
	⊢	-	MYER-KUM"	⊢	-	-Marija 2-04	4	(II) APPE (TE POLLE		DIRENT	TATE OF A	4		
MC 7	l	hior	CHOLE	ı	۱۴	LONG MICTOR	1	BACK IN SUSPEN		Lir		.		
MC-5	\vdash			_	4		_	SIGN LINE		Ov	er	8		
28. TYPE OF RESERVE	١,	FORMO:	TOME (KIM)		- [AT RESIDE PING PAICE	۲							
The again m														
MC-5			YE> 🔲	Nij	- 1			No	ne					
32. CAUSE OF MA Mishap parachu exited at 7,800 A enced a line ove 2,500 AGL. The	tist AGI r m	was p L and alfun	oarticipa after a ne ction afte	ting orn er n	g in nal nai	a full equipm exit, followe n deploymen	en d b	t day HALC y a slow left) pa	arachut rn in fre	eefall, e	experi-		
			CO	NT	IN	IUED ON N	EX	T PAGE						

WHAT WAS THE MALFUNCTION?

Line over. CORRECTION TO REPORT - Parachute was MC-4 not MC-5. Number of jumps must be more than 8.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Possible unstable pull or packing procedure problem.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Ensure proper training objectives are met and followed to reinforce training.

l.						GENERAL						
1. ONLY BEING WALLIASO			J. DEPARTU	At A	HII	tti	1.	UATE	L	TYPE ALL I		ACIT SEF ND
F BBFB- 8 4 1-27					_			C-130				
i. Operation exercise					1 OZAMD COCATION					& DATE A	MD TIME	
				_	┙					<u> </u>		
S. ALAT ALTITOUS (Feel)			SU (A rols)	ľ	In eterevation (seet)				MOS (A	Instit		IIY (Asan M-Yai)
13,000 Feet MSL	L	130	Knots	_		+2890		<u> 5</u> -	-7		Unl	imited
4				٠.		PERSONNEL			_			
14. NAME Mast. From MY GR	ADE.	334H. &	um·I	ľ		OOPS IN WERE THE	IMI	t•	- 1	IO JUMPE	C & POSIFIE	* 14 ALF1
				1		MC-4	1 E) and	- 1	,	3d 1st]	Dagg
17 TO BE PARACHOTE	14			_	_	TYPE MALFUNC		_	_		ou ist	I ass
(Amerika)	÷			_	т	-Mort Indian	Ť	-				
		-	NYERHUTE	⊢	۲	BLUMWINGT ON	+	PACE IN SUSPEN		DIREG	SPECIFY!	1
MC-4		1 ""		l	l	*104* HC. 04	ı	SIGN LINE		l		500+
21. TYPE OF RESERVE	1.	KESE TVE	TUNK (KIN)	_	_	as he such warming by	_					2001
28. TYPE OF REVERVE 11. RESERVE TO BE CAME. ED PROPERTY IN THE TO REVERVE AT RESERVE TO BE SUIT PROCEEDING.												
MC-4		14-34				1				. T		
MC- 1	<u> </u>		YE>	Nü		<u></u> _				None		
canopy and saw is ceiling for cutaw approximately 1, recovered with n still up. 32. CAUSE OF MALI The cause of this abides by the mather proper proces	ay, 700 o si	the ju 0 feet a igns o CTION alfunctal and	mper ini and land f any da /FAILURE	itia led ma	teo on nge	d cut-away pro- n the DZ without e. The parachut nore space is need ave been due to	te v	dures. The jany probler was out of t	jum ns. the o	per had All the d-bag b verse.)	d canop equiprout the	by at ment was slider was acker
			CO	NΊ	ΓΙ	NUED ON NI	EΧ	T PAGE				

WHAT WAS THE MALFUNCTION?

Bag lock/hung slider

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper packing procedures with extended stows that locked bag.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Reinforce quality assurance supervision of packers.

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. UNIT BEING AMERICAN		Ţ,	I. DEPARTU	Rt A I	Aliki	GENERAL	1.	UAIE	1	TYPE ALE I		S ACITISE® ND
		ľ							L	C-17		
I. OPERATION EXERCISE					51	POTAGO OPA SO	_	· ·	<u> </u>	A DATE A	ND TIME	
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S. ALP * ALTITOUS (Feel)	10	ALUT STEEL	U (A rols)	Ţ	. نا	C ELEVATION (Veni)		12 SURFACE WAR	D5 (4	lastų	TJ. VOSBI	.BY (Pann M-No.)
12,500 AGL	ı	1	130	Unk				4 Kno	ots		Uı	nlimited
4						PERSONNE	L		,			
IA. BAME Mast. from MM G	MDE	. 534k. & U	N-I	I.	5 EC	₩₩₩₩₩₩₩₩₩₩₩	IMP	t¶.	П	IO JUMPER	S FOSIFIL	MIN ALP I
				Т					١			
	_				FI	F2, Alt, Helm	et,	MC-4			5/6 1s	t Pass
17 Také kadachoté Gracifel	1			_	_	Pyth(magfigm	(1.0	4				IS NO JUMES
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	ı	иютю	HULE		۱	LOWN HOLD ON	1	BACK IN SUSPEN		Uncle	ear bag	
MC-4	L				Ļ		\perp	SIGN LINE		lock		40
28. TYPE OF REVERYE	1,	RESERVE II	MEA NA		-	AT RESULTING MICH	۲					
	1	"Mo" sapt dem 31h	41- 41		-							
MC-4		v	E> 🗀	Nij	⅃			N	on	e		
32. CAUSE OF MAL	FUN	CTION/I	FAILURE	(If	mo	ore space is need	led	, continue on	rev	erse.)		
After reviewing dures or the mair malfunction - jun cutaway procedu number two wer	the n pa mpo ires	eviden arachut er did n anot giv	nce and e. The pot clear wing end	stat pacl his	ten kir s bu th t	nents, there was procedures urble. When prime for the manner	ere we ull ain	no deficient ere within the ing and no c to inflate. T	icie ne r an 'he	es in the egulati opy, jui lines ai	ons. C mper v	ause of vent into
									_			
			CO	NT	IN	NUED ON N	ΕX	T PAGE				

WHAT WAS THE MALFUNCTION?

Burble

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Appears that jumper did not clear burble. However, insufficient information to determine possible cause.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure training objectives are met and followed to reinforce training with quality assurance supervision.

l.					GENERAL	_					
CONTREING WALLESED			J. DEPARTU	Rt A R	THE	'	UAIE :				S ACITISE ND
						1			Sherpa		
i. Operation exercise					T OZ AND COCATION			\ '	A DATE A	ND TIME	
S. ALA * ALTITUUE (Feel)	10	ALUT SPES	II All and st	1	GERLEVATION (Feel)		TE SUNTACE WAS	75.64.0		11.000	.IIY (Asan M-Yar)
	ľ			- ["	()		1				
12,500 AGL	_	103	Knots	_	PERSONN	E I	4 Knot	ιs			Unlimited
n 14. BAME Mast, first, MA G	(AL) E	5346.44	N·I	T ₁₅	ECOPOLINI MERCAT		· • •	T ₁	. IL MPAR	N PONITIE	DINAL!
14. 11. 11. 11. 11. 11. 11. 11. 11. 11.				-["				ľ			iir i 4 Ma
				Т	Rucksack 40 weight 240 lb		Jumpers	-	7	th of 9)
17 THE PARACHUSE	1.			_	TYM MALFU		4	_			IS NO JUMPS
(Appendix)	H	SEMILIN	YER-KIN'	П	- MANUFACON	ΠÍ	(Hugane (7) arous		DIHENA	PECHAI	1
	Н	hiore		Н	BLUMP WICH UN	H	BAGE IN SUSPEN	\neg	Broke		1
MC-4	1	1		Ιl	222-2-10-04		SIGNICIAE			ol Line	40
21. IYPE OF RESERVE	1.	KESE TVE I	CME (*dM-		as Resulting Mil	bγ					1 10
		ED PROPE "No." sep									
MC 4	l	14-31			1				т		
MC-4	<u> </u>	Y	E>	Nij				<u> </u>	lone		
32. CAUSE OF MALI Main canopy was found were the tw fair wear and tear opening shock co	s recovery	covere broken contro	d. A 100 control	0 pe l line	rcent TRI was es. Both contro ed in breakage	con 1 lir	nducted and nes broke at 1	the the	only a	bnorn -traps. o incre	nalities Suspect ased
			СО	NT	INUED ON N	IEX	KT PAGE				

WHAT WAS THE MALFUNCTION?

Both control lines broke.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Suspect fair wear and tear of control line due to increased opening shock associated with HAHO.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Not given.

I.				GENERAL	_				
1. ONLY BEING WALLESED		J. DEPARTUI	H A	II IELU:	ļ'.	.UAIE 4	C-17		ACIT SEF ND
S. OPERATION EXERCISE				\$1 OZAND COCATION	_			IND TIME	
				i					
S. ALM T ALTITUDE (Feel)	10	ALAF SPESS (Anols)	Ţ	GERLEVATION (Feet)		12 SUNFACE WHATS (Anoty	D VORIL	IY (Pann M-Yar)
800 feet AGL		150 Knots	\perp	387 feet		6 Knots		Not A	Available
H			_	PERSONNE	_				
14. NAME Mast. From MY GR	ADE.	55AH. & UN1	ľ	PODEATAL MONABAT		rt•	IQ TC MLS	K S POSITION	IN ALFI
			ı	Balistic helme BDU (hollyw		d)	l na	ss 3, #3	9 LD
17 TOPE PARACHUSE	4		_	TYM: MBLFUN			ρα	55 5, 115	IS NO JUMPS
(Specify)		SEMPRYEGADA"		AND POOR	П	(Hyape (7) more	DIHEN	ancon	1
		HIOLCHOLE	Г	BLOWN NOT ON	┪	BACK I N SUSAEN	Enta	ngle-	Un-
T-10C Main	L		L	<u> </u>		SIGN LINE	ment	_	known
28. TYPE OF RESERVE	1.	RESERVE FUNCTION ED PROPERLY (M		as Assucting Mich	γ				
'		"Mo" septem m (IV-131)							
MIRPS		YE>	Nij			None			
31. DESCRIPTION OF	MA	LFUNCTION/FAI	LUR	E/ DAMAGE INCUR	REI	D (if more space is no	eeded, cor	ntinue on re	everse.)
he had a normal edhim. They were used to curred with either jumper states that descended below jumper who had they held what they have also on sworn statements. 32. CAUSE OF MALE This was an incident.	inal r ju t ju t hin des neti com com FUN	ble to free ther mper. They be mper exited fr m. About 100 cended below had and exect on NCO withe apletion of the onfirming that	mseoth om fee hinted essectiur the	elves and landed executed PLFs. the aircraft. He t AGL, jumper l m. Jumper state I their PLFs abo ed this entanglen mp) malfunction are were no injur	No sar pecos the ut ner No ies	ith what they he oreserves were wa jumper to be came entangled hat there was near half a second to June and no reserved, continue on re-	ad. No e activ his right in the o time l apart letion o mpers a e deplo	injuries ated. An at who quarisers o to slip a from ea of this pa and rece yments.	octher nother nickly f the way, so ch ass ived
air awareness. The jumper #37 right	ne fa	ailure of maint	air	ing awareness o	ftÌ	he other jumpe	rs in th		
		CO	NT	INUED ON N	EX	XT PAGE			

WHAT WAS THE MALFUNCTION?

Incident - low altitude entanglement.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper performance of third point of performance.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Keep a sharp lockout during descent third point of performance for sustained airborne training.

I. 1. UNIT BEING WALLESED		J. DEPARTU	RŁ A	GENERAL	1.	UAIE FA	1VPE ALEI	L	ACIT SEF ND
. O III BEIII G PAREI - EE		1			,]	C-130		121121-45
S. OPERATION EXERCISE				T OZ AND COCATION	_		A DATE		
				ĺ			1		
S. ALP * ALTHOUGH (Feel)	10	ALUF SPESU (Anols)	Ţ	GERLEVATION (Feet)		12 SURFACE WARDS	(Anzty	D VORILI	IY (Pash M-Ye))
800 Feet	L	130 Knots	\perp	312 Feet		3 Knots		Ur	nlimited
H			_	PERSONNE	L				
14. RAME Mail, From MY G	MDt.	55AH. & UN1	ď	S FOOTHER I MEMBER 1	UMP	t¶	IA JUMPEI	C S POSITION	IN ALF
			1	Rucksack, LBI	7 F	Zevlar	,	01 2	1 D
17 TO BE PARACHUSE	4		_	Trie malfun	_			0L, 2nd	1 Pass
(Specific)	H	SEMILINYEGHUN	Т	-MATERIAL INC.	Ť	(Hugane 17 E aroug	LL DIRENTATECTIVI		1
	Н	HIOT CHOTE	T	BLOWN NOT ON	7	BAC# IN SUSPEN	+	ngle-	1
T-10C	L	1		l		SIGN LINE	men	-	UNK
28. TYPE OF RESERVE	1.	RESERVE FUNCTIONS ED PROPERLY AV		AT JERREDWO MICH	γ				
		"No" septem m dem 31h							
MIRPS		YE> 🗆	Nij			L Buttocks			
because the low #10. They lande serious. The foll his suspension li jumper #10, the the twist came o pension lines we him but he could 12. CAUSE OF MA This was an incexit and twists ocontrol.	d 5 owines hig ut o ere 1 ln't	to 7 feet aparing statement is and was able her jumper. Just the lower just tangled in the They landed INCTION/FAILUI ont, not a malful	t. Ju wa to imp mp har wit	amper #10 injures taken from the bicycle free and her #10 initially ber's suspension hess of jumper #10 in serious injures of jumper #10 in serious injures in no serious injures inju	lov gai gai ine #10 ries	his left buttoo wer jumper. H n canopy con inced off the les. The lower b. He told jum s.	ks but of e states trol who ower jun jumper per #10 reverse.)	lid not the had the had the he no mper's conticed to clim	hnk it was wists in ticed canopy as his sus- b down to
		CO	ΝΊ	'INUED ON N	EX	KT PAGE			

WHAT WAS THE MALFUNCTION?

High altitude entanglement.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Insufficient information.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Not enough information to determine cause.

I.			—	GENERAL	=		_	_	_	
T. ONLY BEING WALLESS		J. DEPARTURE	i A RI		7.	.UAIE	1	т ур е ацті СН-47		S ACITISE® ND
B. OPERATION EXERCISE			$\overline{}$	1 OZ AND KOCATION			_	A DATE A	AMD TAMÉ	
S. ALAT ALTITUDE (Feel)	10 AU	F SPESU (Anols)	Tir	GERLEVATION (Year)		12 SUNTACE WAS	ADS 6	Anzių	13 3/5/80	LUY (Vann M-No)
1500 AGL	<u>U</u> 1	nknown	L	Unknown		J 5 Kn	ots	<u> </u>	<u> </u> U	nlimited
H.			_	PERSONN	έL					
14. BAME Mast. from MV G	HADE, SSA	h. 4 UN1	15	FOOTH SHI WERKEY	IUMI	/Eq	\neg	IQ TO MLS	K V POSITIE	IN IN ALE
			L	Combat equ					R4, 1 I	Pass
17 TO BE PARACHOTE				Pythi manging						IS NO JUMES
(AcestVI	21	EMITAYES HUM	\Box	egen his com	\Box	(II) AND ITS WOLL		DI HEM	(APPENDATE	
MC1-1C	h	1) () (HU[E		etowwi(104		BACKETH SUSAEH SIGN LINE		Entan ment	_	12
ANTER DE RESERVE	607 786	EPVETUNETCHE PROPERTY IN of Replain in III YES IN I	Nij	as Nesuc Ping (NIO	ìγ	Non	ne.	•		
	=		=		_	1,01	_			
			_		=		=			
31. DESCRIPTION O Higher jumper's sta saw lower jumper a	atement about 15	t reports a good 50 feet and 40	od ex feet	xit and full deplo	yme h bot	ent of main pa oth jumpers tra	arac acki	hute. Hi	igher ju truck on	mper then n the DZ.

20M of separation. Lower jumper then turned right to avoid higher jumper but brought them closer together. Higher jumper then spread eagled to bounce off lower jumper's suspension lines but became entangled in suspension lines about 16 inches below the anti-inversion net. Higher jumper then tried to weave his way out of lines but could not, and reports that he saw two good canopies but they wer starting to collapse. Higher jumper then activated his MIRPS and it fully deployed with no faults. Higher jumper reports seeing lower jumper activating his MIRPS about two seconds later and both jumpers drifted to the ground softly. Lower jumper's statement reports a good exit with full deployment of main parachute. Upon third point of performance lower jumper did not see anyone in his immediate vicinity, so jumper released toggles to drift so he could determine wind direction. After 3 seconds, jumper executed a 180 degree turn to his left, and upon letting up on toggles jumper still kept lookout for other jumpers. Jumper then felt sharp change in wind direction and pulled right toggle for compensation and the released toggle. Lower jumper then looked up to see higher jumper drifting directly at him and higher jumper screaming at him to turn away. Higher jumper then entered lower jumpers suspension lines just below anti-inversion netting and became entangled. Lower jumper then reports first one canopy then the other stealing air from each other and higher jumper activating his MIRPS, the lower jumper activated his MIRPS. Lower jumper saw DAD and part of canopy deploy then stall with half of canopy still in pack tray, so lower jumper pulled remaining canopy

CONTINUED ON NEXT PAGE	

31. DESCRIPTION OF MALFUNCTION/FAILURE (continued)

and lines out with right hand. After all lines were out of pack tray, the canopy then fully inflated. Lower jumper states that both main parachutes never deflated. Lower jumper and higher jumper rode four full canopies to the ground without lowering equipment and higher jumper landed 5 feet to lower jumpers front left. Malfunction NCOs statement reports good exits and full deployment of both main parachutes for both higher and lower jumper. Higher jumper then failed to give right of way to lower jumper and passed into lower jumper's suspension lines, becoming entangled. Higher jumper then activated MIRPS and had full deployment with no deficiencies. Lower jumper then activated his MIRPS and had partial deployment due to the fact that both jumpers were already under 3 full canopies (2 MC1-1C and 1 MIRPS). Lower jumper then pulled the remained of his MIRPS canopy and suspension lines from the packtray and his MIRPS inflated fully. Both jumpers then rode 4 full canopies to the ground/trees without injury. The entanglement happened at midaltitude.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

This was an incident/entanglement not a malfunction. Higher jumper failed to give lower jumper the right-of-way and entangled in lower jumper's suspension lines.

ANALYSIS: 18

WHAT WAS THE MALFUNCTION?

Incident.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Failure to perform third point of performance.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reinforce proper procedure during sustained.

				GENERAL					
, UNIT BEING WALLETED		J. DEPARTU	H A F	IIILG	3.		14 7 130	I -	ACIT SE • ND
i. OPERATION EXERCISE				1 OZ AND COCATION	_		& DATE	AND THAE	
AD ALTHOUS (Feel)	10 /	(Clor N) US 374 7 CL	Ţ	GERTENATION (Amel)		12 SURFACE WINDS (An st ų	13 VORILI	IY (Fash M-Ni)
10,000 Ft AGL		130 Knots	\perp	120 Feet		1-2 Knots		5-	10 Miles
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id, RAME Masil, first, MA CA	unde.:	>24#. & UN'1		Danalson als			1st	Pass, 1s	
17 THE PARACHUSE	4		_	Rucksack.			Juli	ipeis	IS NO JUMPS
(Specify)	П	SEMILIPARE/SIGN.		ANTESON	Т	(II) AND (ITE WOLL	DIHEN	ancon	1
MC-4	П	HI OF CHOFE		etowwid on	T	BAGE IN SUSPEN SIGN LINE	Lin	e Over	42
EL LYPE OF RESERVE		CESE PVE TUNK (*CIN-	_	as desucting injuly	,		Lin	e o vei	
		"No" explain m num dith		1					
MC-4		X vE>	Nij			None	<u> </u>		
tumble and coul in an uncontrolled. Aron was deployed. J him. The main p 32. CAUSE OF MAI A 100 percent T between the A a parachute near a cause of this mal was caused by the while in this uncontrolled.	able und ump arac FUN TRI nd E n fen funce	tumble. Upor 4,800 feet AC per then lande thute was not action/FAILUR was conducted lines. No other. The main ction was due acksack shoul	n op GL, d o fou E (H d o ner wa to a der	sening, the parace SM performed ff the DZ. Jump and. The more space is need to the reserve parace damage was four short recovered an opening while strap breaking version.	chucu er ede rad ind afi	ute had a line on the away proced #2 landed at the decision of the continue on received. This was due ter a lengthy see an uncontrollatile exiting the a	everse.) tear or e to the earch ouble tur	nd a goo help in the top e recove f the are mble. Th	skin ry of the a. The e tumble

WHAT WAS THE MALFUNCTION?

Unstable pull..

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Equipment failure caused an unstable pull.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure soldiers inspect all air items.

l.				GENERAL	_				
1. ONLY BEING WALL TED		J. DEPARTUI	M: A F	HIELE] '	.UAIE [4	TYPE ALI		ACIT SET ND
S. OPERATION EXERCISE				\$1 OZ AND VOCATIO	1		C-1.	30 L	
S. ALAT ALTITUDE (Feel)	10 .	ALUT SPESS (Anols)	Ŧ	GERLEVATION (Feet,		12 SURFACE WHOSE	Anoty	13 Visibili	IIY (Assn.M-Yer)
800 feet AGL	ı	NA	Т	274 Feet MS	L	3 Knc	ots	Clear	5 Miles
H				PERSONI				T CACAL	- / WIIIC.S
14. BAME Mast. From MM G	MDt.	55AN, & UN-I	15	FOOD-ATAL MORAL	r JUM	rta	IQ TC AL	ek y rosiriur	FIN ALFI
			Т	Para. Ballisti				15.1	
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17 To be baseachode (Souciful	Ľ	-		FyM; Majfe	,M(1:()		_		IS NO JUMPS
	Н	SEMILINAE CHICA.	Н	- MANIFESTER	Н	(IGAME ITE MOLL	DIHE	4 (APECILY)	4
T-10C		PI OT CHOTE	X	BECOMM MICT ON	X	BACK IN SUSAEN SIGN LINE	1		12
21. TYPE OF RESERVE	7.	KESE OVE TUNKLÍKUM:	ш	as NesucPino (N)	UBY		_		1 12
	ļ	ED PROPERLY AN		1					
MIRPS	l	14-311 VE>	Nij	1		None			
WIIKI S	<u> </u>		~:			TTOTIC			
mately 100 feet and NCO observed to before the jumportended and separathe way inflated and the main car approximately 5. 32. CAUSE OF MAI After completing that indicate the another jumper stick's stagger to during deployment.	he I	DAD launch a anded, the suspend from all other eposition of to was directly at 75 feet of altimated and percent This parachute vanopy) The #1 etimproper. We	nd to be not be not be not be laborated with the laborated laborat	the MIRPS unsion lines and ems of equipm MIRPS in relave him. The jue, the MIRPS of the T-10C pacted upon by nper, right doche damage diche dimage diche diche dimage diche d	obsithe chent ion mper would be aracor, he scover	canopy of the No. The canopy we to the jumper or then landed we ld have fully in the continue on rechutes, there is coutside source esitated in the covered on the seconds.	ment s MIRPS was ap was at with no iflated everse.) s evide (i.e. a door ca	sequences were fur proxima a 45-dego injuries as designence and nother juausing the system, v	e. Right ally ex- tely 3/4 of gree angle s. Given ned. damage amper or the entire we feel that
		CO	NT	INUED ON	NEX	XT PAGE			

32. CAUSE OF MALFUNCTION/FAILURE (continued)

from the opposite door that was also deploying. The suspension line burns match the pattern of the burns on the jumper #1 canopy. The damage on canopy #1 was caused by the canopy #2 suspension lines interaction. When both canopies fully inflated, they separated. It is possible that during the deployment phase, the second jumper's foot got caught in the anti-inversion net/lower lateral band area. This would explain the black kiwi-like stains. These two situations caused the skirt of the #1 canopy to become constricted. With the air still trying to force its way into the air channel, the violent fluttering of the nylon caused the friction type burns. When the main forcibly deployed, the damage occurred.

ANALYSIS: 20

WHAT WAS THE MALFUNCTION?

Blown section and broken suspension lines.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Simultaneous exit. Contact between jumper's parachute and other parachute or jumper.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Ensure exit performed IAW.

TAR&M/SA VOL III

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l.					GENERAL						
1. ONLY BEING WALLESS		J. DEPARTU	At A	All	HG	1.	UATE	1	TYPE ALL I	T	S ACIT SEF ND
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MC1-1C	<u></u>		L	L		_	SILEN LINE		Line		1 20
28. TYPE OF RESERVE	1.	RESERVE TUNE (KIM-			AT RESULTING MICH	•					
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MIRPS		YE>	Nij	i			None				
											
32. CAUSE OF MALI The left control li					-			on rev	verse.)		
								_			
		CO	NT	ΓI	NUED ON NI	EΧ	KT PAGI	Ε			

WHAT WAS THE MALFUNCTION?

Broken control line.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Possibly not proper adjusted - not enough information.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Follow proper pack/PIS procedures.

l.				GENERAL						
1. ONLY BEING WALL TED		J. DEPARTU	R A I	HIELG	1.	UATE	L	IMPE ALL I	- 1	ACIT SE MD
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i. OPERATION EXERCISE				T OZ AND LOCATIO	•			ik Date a I	ND TIME	
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(Specify)	-	INVERSION.		- MATERIAL M	П	(10 APE 17E 1	rou.	DIMPR	arecuvi	1
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				7.5						
awareness after the instructor and car deploy their main delay caused their deploy their rese further incident. COI due to poor 32. CAUSE OF MAL Loss of altitude at the instruction of	meramar paracht r airtec c rve para Consequ judgeme	n then per utes at the cypress ex chutes. B nently, bo ent.	for eir p xpe soth th i	med an unauth prescribed depirts (automatic jumpers land instructor and d	oriza oym oper ed un eame	ed freefa nent altitt ning dev nder their eraman v	ll mand tudes. T ices) to r main were rel	euver a This ma activa parach leased	nd faile aneuve ate and autes w	ed to r and partially ithout
		CO	NT	INUED ON	NEX	KT PAG	E			

WHAT WAS THE MALFUNCTION?

Incident - Two ADDs fired.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Lack of altitude awareness - Failure to maintain awareness.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Follow proper procedures and doctrine.

1					Contac:						
. ONIT BEING WALLISED		J. DEPO	KINE	k A A	GENERAL	1.	UAIE	4 1	MPE ALE I		S ACITSE ND
						1			C-1	7 	
i. Operation exercise					1 OZ A4D COCATION	•		٦	A DATE A		
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4. BAME Mast. from Mill G	MDt.	. 55AN. & UN1		15	FOOTH SHI WORKEY	IUMI	't¶	T	6 JUMPER	t y rosiriu	IN IN ALE
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II. IYM CU RESERVE	11	KESE PVE I CML (*		_	as Result Ping (MIO	ìγ					• /
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MIRPS		YE>		Nij			None				
1.1114	_						1,0110				
32. CAUSE OF MAI This is not a malt button on his sle	unc	ction. This	is ar	1 ac	cidental reserv	e ac	ctivation. Pro	oba	ble cat	use; the	e jumpers
		(C O I	NT	INUED ON N	ΈΧ	KT PAGE				

WHAT WAS THE MALFUNCTION?

Incident - Accidental reserve activation.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Not enough information to determine.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure malfunction NCO properly supplies information on 1748.

l.					GENERAL					
1. UNIT BEING WALLISED		J. DEPART	JRŁ A	HII	tli:	1.1	IAIE (4 TYPEAUL		S ACITISE® ND
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E. OPERATION EXERCISE				1	1 OZAAD KOCATION			A DATEA	MD TME	
			_							
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4			_		PERSONNE					
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			١		AC-4 HALO S	Stic	k, Gentex	l	// 2 T •	C /T //O
			_	ŀ	<u> Ielmet</u>				#3 L1	ft/J#2
17 Také kadachauté (Sakata)	*		_	_	FYPE MALFUN	(1:01		_		IS NO JUMES
	H	SEMITHYER/ICH.	╇	+	-MALES-CHI	+	(HUMME OF MOLL	DIHEN	(JPECILY)	⊣
MC 4 MEE		HIOLCHOLE	ı	ı	BECOMPANY AND ON	1	BACK IN SUSPEN	Hur		
MC-4 MFF	L		_	_		_	SIGN LINE	Slid	er	MFF: 35
28. TYPE OF RESERVE	١,	RESERVE FUNCTIONS ED PROPERLY (M			AT RESULTING MICH	7				
'		"No" explain m dam 31h	_							
MC-4		YE>] _N ;	ü	<u> </u>		None			
reserve parachute The main canopy were still stowed and the suspensio 924 which corres previous MFF jur pulled the main r his slider, but it w parachute to fully trying to inflate th sion lines and got noticed the canop	and	d the jumper d the equipmoines were tan nded to a 250 s) stated he vord and look not coming deflate. The jumpanopy. The junck again. Th	lantent glee 0 fe vas ed u own per umj	de ha d d d deet in up in the rest of the	d in a cotton fid no apparent lue to the cutay AGL setting. stable free fall to check his case suspension lated that he result was the	eld dan vay Wh fro ine ine pea sli	. I noted that nage. The slid The FF2 milen interview om 13,000 fee py. He stated is (hung slider tedly pulled oder started to ne problem. I	both bra ler was llibar di ed, the j et AGL. that he). Thus a lown or slide do	nkes (to midwa al setti umper At 4,0 could not allo n his re	oggles) ay down ing was at (with 34) 000 feet he clearly see owing the ear risers, he suspen-
		CO)N'	ΓI	NUED ON N	EX	T PAGE			

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

After interviewing the jumper, I concluded that this post opening malfunction occurred because of a hung slider. I estimated after his main canopy deployed at 4000 feet AGL and was cutaway, the jumper was under a fully functioning reserve canopy by 2000 feet AGL. Improper emergency procedures were exercised during the deployment sequence. The jumper pulled down on his risers to try and clear the problem. If the jumper would have unstowed his toggles and properly attempted to resolve the problem by pulling down on the brakes (correct procedure for a hung slider), I believe he could have cleared the slider problem and landed the main canopy without incident. The equipment (with special attention to the slider) was 100 percent technical rigger inspected and was found to be completely serviceable without any damage resulting from this jump.

ANALYSIS: 24

WHAT WAS THE MALFUNCTION?

Hung Slider.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Cutaway caused by hung slider.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Follow proper emergency procedures for hung slider.

TAR&M/SA VOL III

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. O THE BEHNG PARTY TEV			J. DEPARTU	M: A I	GENERAL	1.1	UAIE	1 41	MPE ALET		S ACITISE® ND
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i. Operation exercise					\$1 OZ AND COCATION	_		٠,	A DATEA		
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SP-170							SIGN LINE		Bag	g Lock	
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Tempo-210	l		vE>	Nij			No	ne			
32. CAUSE OF MAI After a 100 perc stow next to it. T	ent	TRI,	I found	the	bag lock was ca					ing arc	ound the

WHAT WAS THE MALFUNCTION?

Bag lock.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Tube stows possibly worn out.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Inspect equipment and follow pack procedures.

I.					GENERA						
. UNIT BEING WALLISED			J. DEPARTU	Rt A R			UATE	14	IMPE ALET		S ACITISE® ND
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12,5001 CCT TGE	_	1501	Kilots	_	PERSON	NFI	1 3 Kilot	.5		301	VIIICS
14. BAME Mast, first, MM GR	AD)	MAR A	hN·I	Tis	FOOTH SHI WORK		P+ 1	\neg	IA JUMPER	S PONEII	MIN ALPI
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17 TOPE PARACHUSE	4			_	Tyte mage			_			13 NO JUMPS
(Specify)	ŕ	,,,,,,	MYER-KUM"		- MANIFES COM		(NAME OF FOLL		DI BER S	ancieri	-
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ers canopy.											
			CO	NT	INUED ON	NEX	XT PAGE				

WHAT WAS THE MALFUNCTION?

Uncontrollable spin.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Unstable body position on pull.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Pull stable/reinforce training.

I. 1. ONIT BEING WALLISTED					diameter.					
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S. OPERATION EXERCISE				_	1 OZAAD COCATION	1			IND THE	
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1300 4	_	70 Knots		_	PERSONNE		1 / Kilot	3		<u>Inlimited</u>
n 14. BAME Mast, Cross, MA GA	44111	MAL BING		T ₁₅	TOURNESS THE PROPERTY			LA II MEN	K S POSIFIL	F-14-1-1-1
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WHAT WAS THE MALFUNCTION?

Riser not sewn.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- Failure to properly inspect equipment during PIS.
 Factory did not catch the defective equipment.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- Follow TM for in-servicing and packnig.
 Be more diligent on QC of manufacturers.

l					_	GENERAL			_			
1. ONLY BEING WALLESS			J. DEPARTU	Rt A I	AllE	Lib	1.	UAIE .	41	MAE WITH	,	ACIT SE • ND
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E. OPERATION EXERCISE			•		ľ	OZ AND COCATION	_		٦	A DATE #	ND TIME	
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28. TYPE OF RESERVE	1.		TUNK (404)		T	as ResourPing (MIC	ŀγ					
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MIRPS VES X NU None												
tion (compare ra faster or not. Ch snapped into a ti pilot parachute v to pull the canop direction of spin it away from his to land. Jumper l get out and away	eck ght wer y b . Th fac and	ting the body not out a count	ne canop position and up. 'n and re- erve star abserve v ithout in	y ag The Clep ted whe jury	gai d a e ca olo ag ere y a	in he observed his anopy started y the parachigain to up throthe was at an and recovered to the was at an	ed the MII de to the MII de to the MII de to the MII de to the MII de the MII	nat the tear ware RPS. Upon do cover his factory throwing in the main cate had been lowered by the the main cate had been lowered by the lowered by t	as ep e a it d no nis	not get loying and the lown a ppy so t s equip	tting lathis MI is jumpe nd awathe jum ment to	rger and RPS the er started by in the eper pulled oprepare
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32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Upon opening shock, the main canopy incurred damage to the stated section (partial - section 3, gore 11 tear from diagonal seam to both radial seams, approximately 2 inches wide) and led to the jumper possibly having less lift capabilities than his fellow jumpers. The damage may have been caused by material weakness or degradation over time. By deploying his MIRPS, it was discovered that he still had good lift capability and that was a probable cause for his reserve not to fully inflate.

ANALYSIS: 28

WHAT WAS THE MALFUNCTION?

Torn Gore

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Not enough information.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Inspection of equipment during packing process.

I.				GENERAL							
*. ONLY BEING WALLESED		J. DEPARTU	Rt A R	IIELG	'	. U.A.1	TYPE ALF		ACIT SE • ND		
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12,500 FtAGE	150	KIAS	_	PERSONN		1 10101	013	1 UIIII	mied		
14. BAME Mast. first. MM GA	IADE, SSAN.	4 UN-1	15	FOOTH SHI WORKE		rt¶	IO JUMPA	ER S POSIFIUM	MALFI		
			Т	Gentex, Gogg	les.	Gloves.					
				Altimeter, 02				14			
17 Také kadaghuné (Amerik)	· II			Pyth(magfi	M(Ta))4			IS NO JUMPS		
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	HIGH CHOPE BLOWN WICH ON BACK IN SUSPEN Floating										
MC-4	oxdot		Ш		Ш	SIGN LINE		ocord	Unknown		
28. TYPE OF RESERVE		VETUME (KIM)		au Resul Pino (Mir	μkγ						
	fator demi	esplais m									
MC-4	X	YE>	Nij]	None				
pull at 3500 feet housing, found it dures at 3000 feet or upon landing. 32. CAUSE OF MAI Jumper exited a free of its pocked identify the floath his pull at 3500 ripcord cable, where the same pull	E but count and we have and we have a trained at this feet. He	on/FAILUR time. Jumpe cord. Jumpe located t	ed an per line in	y ripcord cablerve canopy by The more space is reported in the rip of the ri	e. I t y 27 neede on an (reef	ed, continue on rexit. The main 22 mask that in all, waived at 4 and attempted to	everse.) ripcor	te cutawa s under o rd was kr I his sigh ret and in	ay proce- canopy aocked t to itiated		
		CO	NT	INUED ON I	NΕΣ	XT PAGE					

WHAT WAS THE MALFUNCTION?

Floating ripcord.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Could not locate after collision.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Jumper followed correct procedures.

l.					GENERAL						
CONTREING WALLESS		J. DEPAR	URŁ A	N MI	ELG	3.	UATE	1	TYPE ALE I		S ACITISE ND
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i. Operanom exercise					1 OZAND LOCATION				A DATE	IND TIME	
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4					PERSONNEL						
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17 TO BE PARACHOTE					FYM; MALFUNK	1.0	4				IS NO JUMPS
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T-10C							SIGN LINE				8
28. TYPE OF RESERVE	1.	RESERVE FUNCTION ED PROPENLY (W			as Resulting Michigan	,					
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32. CAUSE OF MALI					_					n the p	art of
		C	ON'	TI	NUED ON NI	EΧ	XT PAGE				

WHAT WAS THE MALFUNCTION?

Entanglement.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Simultaneous exit.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Emphasize exiting procedures.

l.					GENERAL							
1. ONLY BEING WALLIASO		J. DEPARTUI	H A	HIII	tli:	3.1	UAIE		VPE ALF I	3	ACIT SEP ND	
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4					PERSONNEL							
14. NAME Mast. From MM GR	MDE.S	53AH. & UN1	ľ	> t	00 PR 191 WERR BY I	IMI	t¶	li	O JUMPER	CS POSITION	IN ALFI	
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		High Altitude										
T-10C	Ш		L	Ļ		\perp	SIGN LINE		Entang	glement	UNK	
28. TYPE OF RESERVE		CESE PAR LOWE (FOR F			AT RESULTING MICH	•						
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MIRPS Lower Back												
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32. CAUSE OF MAI The probable cau approximately th	ise o	of this high alt	itu	de	e entanglement	is	both jumpers		Í	ne aircr	aft at	
								•				
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WHAT WAS THE MALFUNCTION?

Entanglement.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Simultaneous exit.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Emphasize exiting procedures for both jumpers and jumpmasters.

l.					GENERAL					
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4					PERSONNI	L				
14. BAME Mast. from MM GR	MDt.	534H. &	un-i	15	10004141 WG84 BY	шмг	t=	IO JUMPS	K S POSIFILI	YIN ALPI
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28. TYPE OF RESERVE	1.	KESE TVE	TUNK (KIM)	_	as Resulting Mile	ıγ		LILL	1 111313	•
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NATE 1 C		14-31			1					
MT-1S	<u> </u>	LXI	YE>	Nij				No	one	
					72					
Jumper was last in After exit and op successfully rem and that drogue place canopy and was in an attempt to a Cutaway procedifurther incident 1 32. CAUSE OF MAI Poor body position wing aircraft.	eni ove para infl ilea ure 0 n	ng sheetwist achute ated b r the c s were neters	ock, jum ts. He the e and dro behind th drogue w e initiate s from IP.	per en n ogue te tra vithe d at	noticed line two oticed only the econtrol line we ailing edge of the out success. Ca approximately	ists out ere ne c nop 270	and performe er sides of his over the nose canopy. He per by was unstab 00 feet AGL	ed corre canopy , routed rformed le and u Jumper	ctive active act	tions to inflated the main imic stall ollable. without
			CO	NT	INUED ON N	EX	KT PAGE			

WHAT WAS THE MALFUNCTION?

Pilot parachute over the nose.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Unstable exit.
- Poor body position.
 Inexperienced jumper.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Standardize training and reenforce proper exit procedures.

TAR&M/SA VOL III

SEMI-INVERSION INVERSION (III, AMETE MOLL DITTER (SPECTIVE) HIGH CHOPE BLOWN WICH ON BACK IN SUSPEN							-						
Casa 212 OPERATION EXERCISE 1 OF AND LOCATION 1 A DATE PROTOME ALLA" ALTITUDIE [PRAIL) 3.000 Feet 130 Knots 130 Knots 1 DE ELEVATION [PRAIL) 3.000 Feet 130 Knots 1 DE ELEVATION [PRAIL) 3.000 Feet 130 Knots 1 DE ELEVATION [PRAIL) 3.000 Feet 130 Knots 1 DE ELEVATION [PRAIL) 1 DE ELEVATION [PRAIL] 1 DE ELEVATION [PRAIL) 1 D	. UNIT BEING ACRES SE	_		J. DEPARTU	R A I		MAL	3.1	UAIE	Ŧ.	TYPE ALE I		S ACITISE ND
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PERSONNEL A. NAME SAME CALLED STAR. & UN-1 SECURE PROPERTY INCREMENTATION INCREMENT	AUT AUTOUS (Feel)	10	ALUT SEE	SU (A nots)	Ţ	GIELEVATION	(feet)		12 SUNIACE	MHD51	Anotų	13 7/58	LITY (Pash M-Yer)
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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.) Jumper exited the aircraft at 3,000 feet AGL for a clear and pull. He could not locate his hand-deploy pilot parachute and performed cutaway procedures. Jumper landed safely on the DZ with his reserve. 32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)	Ravin II M				Nij	1				Nor	ne		
Jumper exited the aircraft at 3,000 feet AGL for a clear and pull. He could not locate his hand-deploy pilot parachute and performed cutaway procedures. Jumper landed safely on the DZ with his reserve. 32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)							.7						
	Jumper error du	e to	inexp	perience									
				CO	NT	INUED O)N NE	EX	T PAG	E			

WHAT WAS THE MALFUNCTION?

- Could not locate hand-deploy pilot parachute.
 Performed cutaway and activated reserve.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Inexperience with low altitude clear and pulls.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reenforce training.

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and interfering wi	FUN	CTION/FAILU	RE (nore space is nee	ded	, continue on r	everse	e.)		
		C									

WHAT WAS THE MALFUNCTION?

Jumper flipped through risers inadvertantly activating his reserve.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Poor exit.
- Not familiar with new exit procedures.
 Equipment too heavy.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- Reenforce exit procedures.
 Ensure jumpers weight no more than 360 lbs.

l.					GENERAL			_			
1. ONLY BEING WALLISTED		J. DEPARTU	Rt A	MI II	ill.	3.1	IAIE	[1]	IMPE ALL I		S ACITISE® ND
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i. Operation exercise					MOTADADADASO 1				A DATEA I	ND TME	
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WHAT WAS THE MALFUNCTION?

Hung slider.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper packing procedures.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Follow proper packing procedures IAW manufacturer.

LOWING BEING ACREED 1. DEPARTURE A RITELD 1. DATE AND TO C-130 K. OPERATION EXERCISE 1. DE AND LOCATION 1. DATE AND TIME K. ALL- ALTITUDE (Final) 10 ALL STEED (A 1015) 11 GET ELEVATION (Final) 12 SUNI ACE WARDS (ARDEL) 13 VISIBILITY (FINALMANIA) 18 800 Feet AGL 120 Knots 387 MSL 5 Knots Unlimited PERSONNEL 14. RAME MAIL STAIL MY GRADE. SSAN. 4 UN-1 15 EDUPMENT WERN BY JUMPEN 10 JUMPER'S POSITION IN ALL KEVIAR, LBE #14 1/d 2 pass	•					GENERAL						
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WHAT WAS THE MALFUNCTION?

Inadvertant reserve activation.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- Weak exit.
 Inexperienced jumper.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reenforce exit procedures.

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WHAT WAS THE MALFUNCTION?

Inadvertant reserve activation.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Ripcord grip awareness/control.
 Ensure proper ripcord is being used with the MIRPS.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reenforce first point of performance.

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WHAT WAS THE MALFUNCTION?

Premature reserve activation of reserve in aircraft.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

1. Ripcord grip awareness.

2. Jumpmaster may not have maintained three points of contact.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Maintain control of ripcord grip.
 Jumpmaster needs to maintain body control and proper body position.

I.						GENERAL						
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WHAT WAS THE MALFUNCTION?

2 broken "A" lines.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Blunt cuts on cascade to A lines inside finger trap.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

TRI parachute prior to use.
 Monitor number of jumps on canopy.

					GENERAL						
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WHAT WAS THE MALFUNCTION?

Pilot parachute retraction system entangled.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper setting of the kill line.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- Ensure jumpers are properly trained on equipment they are using.
 Ensure kill line inspected during JMPI.
 Need more information.

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32. CAUSE OF MAI				-	edeo	d, continue on	reverse.)	
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WHAT WAS THE MALFUNCTION?

Pilot parachute hesitation.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- Pilot parachute worn out.
 Improper packing.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- TRI equipment.
 Ensure jumper is proper trained on the equipment they are using.
 Need more information.

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WHAT WAS THE MALFUNCTION?

Twisted suspension lines.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- Improper body position during pull.
 Improper packing procedures.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- Ensure parachutes are packed IAW manufacturers recommendations.
 Ensure jumper pulls stable and on heading.

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32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The probable cause of this situation was the inexperience of the jumper.

CONTINUED ON NEXT PAGE

WHAT WAS THE MALFUNCTION?

Premature activation of the reserve by jumper.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- Starting 4 second count too early or counting too fast.
 Inexperienced jumper.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Reenforce training in five points of performance.

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CONTINUED ON NEXT PAGE									_			

WHAT WAS THE MALFUNCTION?

Closed cells - line twists.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Jumper not stable or on heading during pull.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure jumper is stable and on heading during pull.

l.					GENERAL						
CHITEBING WILLIAMS		J. DEPARI	URŁ A	MI II	::::	Ţ	.UAIE F	1	upeadei Unk	,	ACIT SET ND
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WHAT WAS THE MALFUNCTION?

Premature activation of main canopy.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Unstable exit, tumbling, inexperience.
 Jumper has experienced problem in the past.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Reenforce training.

CARGO MALFUNCTION REPORTS AND ANALYSES

l.			G	ENERAL						
1. JAIT BEAG A HUTTEU	A. OEFA CIORE AMPLEU			j V≜iç			C-13		> 40" 56# 40	
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Type V			1.					1		
8 foot	G-11	B(1)	15 Foo	nt Ring S	Slot				FS 360	

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)
The extraction sequence and the deployment of the single G-11B were correct. As soon as the M-1 release had tension from the almost fully inflated canopy, the finger attaching the G-11B to the M-1 release prematurely released. Upon inspection of the finger and the main body of the M-1 release there was no visible damage found. Upon disassembly of the M-1 and five test of the timer block, it was found that when the timer was armed the keys would extend but when the arming wire was inserted and the screwdriver was removed the timer would wind down enough for the keys to retract. One out of the five test resulted in the keys not retracting after the screwdriver was removed but could only be accomplished by inserting the arming wire with the bend in the wire facing downward. It could not be determined if the damage to the timer block was a result of the impact. The timer was tested at 16 seconds two days prior to the malfunction. The load was jointly inspected by five personnel

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The timer block was defective. When tested after the malfunction, the timer never fell into the correct time but could be armed with keys extended some of the time. This is why it passed the JAI.



WHAT WAS THE MALFUNCTION?

Timer failed.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Arming of the M-1 release and training of personnel.
- 2. Possible screws on face plate not seated properly.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Supervision of rigger personnel.
- 2. Thorough inspection of the M-1 release.

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1. JAIT BEAG A HULLEU	2.0694410	RE AMPLEU	1 0	• I e	4 "YPL A		> 40" SER ME
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M198 Howitzer	FM 10-527/	T-	D. PLATHORNS	Mix. (4	DATAMATAS	7	
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Type V 31. DESCRIPTION OF M During flight, the scate the safety loo the aircraft returned of the extraction p	safety loop work p over the bent V d to base. Proble	ed its way up a ring but was ms were enco	curred (if and over t unsucces untered v	more space is he bent V sful and a vith the sa	ring. At no drop fety loop	tempte was c	ed to relo- alled and g the rigging
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WHAT WAS THE MALFUNCTION?

Safety loop was over bent V rings.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Pendulum line not tight enough to prevent loop from getting over the bent V ring.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Recommend fixing the 28-foot d-bag to ensure that the pendulum line is strong enough to ensure that the parachute is tight. Do away with the safety loop.

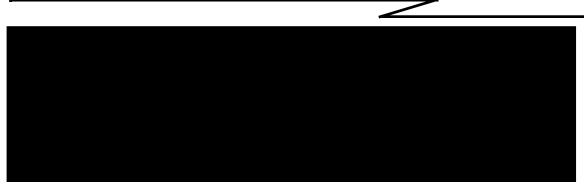
I.			ENERAL							
1. JAIT BEAG A HUTTEU	2. DEPARTOR			U≜lc	<u> </u>	C-130		> 40758840		
§ OPERATION LEFROISE	'	7 117 450	TOLYLKIM			# DATE	AMO TIME	•		
1250 AGL	130 Knots	397	7 Feet	4-7 knots			7 Miles			
HI.			CARGO							
33. INFELDADIANO WIGHT	AN MADRICHMAN (MICH	24 BAGGED FAMILY FAMILY AND MAKE 1				ARRAI DELIVEN AAZIEN CAKO				
M198 (155 Howitzer) 22,860 LBS	FM 10-527/ TO 13C7-10)-191	BOAL RA	o	EDS FIX LA NO. CONTA		atk	jč - sva ≠)		
26 TYPE P. 41*CINIA N DROP CONTACTS	71 TYPE PARACHUPE AND HUMBEN	. LEASE	Foot	74	(é⊌uT⊣OºĤ .iME	[6f PG	la PON Mai	Part Part		
Type V	G-11C (5)	Extr	raction				l	1 of 1		

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

Extraction parachute from the load of the M-198 deployed properly. The five G-11Cs deployed and functioned correctly. The load was coming down and landed fine. The load was then lifted off the ground about a half a foot and slid over about six feet. The G-11Cs were still inflated and then started to roll the platform over. On the way over, the G-11Cs were released. The G-11Cs were released in the direction of the wind. The M-198 ended upside down. The M-198 appeared to only sustain cosmetic damage. The platform sustained no damage. There was no major damage on the M-198. Some of the items on the 2404 were M171 level vials do not illuminate. Brakes do not operate properly. M17 does not illuminate. FCAT required.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

M2 did not reach the critical angle in order to release the parachute release connectors that were attached to the five G-11Cs. This caused the G-11Cs to stay inflated after the M-198 landed on the ground. The G-11Cs were released when the load was overturned. The M2 release was tested and found to be in the 14-14.5 second range ten out of ten times. The suspected cause for the M2 release not to disengage the parachute release connectors would be due to high winds keeping constant tenstion on the release.



WHAT WAS THE MALFUNCTION?

M-2 release did not release upon impact with the ground.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Due to high winds, the M-2 did not reach the critical point needed for it to release.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Get out of the vehicle when checking winds.

l.			G	ENERAL							
1. JAIT BE 66 A HULLEU		A. OEFA CIURE	AMPLLU		J D⊕1c			# TYPE ACT:			> AUTSER NO
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HI.				CARGO							
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	l			1004	LAAL		C35 # ::	(Lay	S CATE	a votk	(total)
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9900/10380 LBS	•) 13C7-1		! ,		1				l	
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25 TYPE P. 411/CRM A N DROP CONTACTS		MANCHUPE KU PB EN	LEASE	PARACH, TE			. IME	- HL	tr PG		APEL HEROLOGIE
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16 Foot x 2	4 (+-1	1R(2)	1 2 x	22-Foot	1					1 1	$g_{r} = 2 \text{ of } 2$

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

Both loads extracted late and landed. in the trees off the drop zone. Both platforms were found to be on their sides, with the right side to the ground. Both HMMWVs sustained damage. All air equipment appeared to be in full functional order. The G-11 parachutes were fully deployed and within 50 meters of each platform. On the rear clevis restraints of the second platform were found three sets of steel chain tiedowns that are used to secure platforms inside of the cargo aircraft. The extraction parachutes were found within 200 meters of each load. The extraction chains did not appear to have damage, although it was approximately 50 feet in the air and draped across two trees. The canopy sustained extensive damage during recovery from the trees.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Cause could not be determined. The extraction parachute for load 1 of 2 has been sent to Natick.



WHAT WAS THE MALFUNCTION?

Extraction parachute did not inflate fully.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

The extraction parachute did not fully inflate initially and they were chaining it down. Then the extraction parachute inflated and extracted the load.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Check the rigging procedures for the extraction parachute.

l.	•	G	ENERAL							
1. JAIT BEAG A HULLEU	1.089410	RE AMPLEU	MELU I DATE			k -yrk aci C-1		> 40" 56# 40		
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			7_							
HI.			CARGO							
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HMMWV	FM 10-517/	/	NO. PLATFOR	IM2	40.1044	Numero S	1			
9750 Lbs	TO 13C7-1	-111	2							
25 TYPE PLATFORM A R DROP CONTACTS	71 TYPE PARACHOPE AND NOWBEN	48 5/76 EX	T4+C*H#+ #[648#(H _U TE	1	/a (GMGTH OF G .IME	IEFF PG		Property (OA), H Party		
Type V 16 Foot	G-11B(2)	. 22	Foot				3	& 4 Second		

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

The load was the second of a sequential drop of M966 TOW carriers. The first load exited the aircraft okay. The extraction parachute and line bag deployed normally on the second load. The load exited the aircraft okay. On transfer from extraction to deployment mode pieces of debris were seen falling from the load. During the deployment phase the rear right hand side suspension sling got caught between the brush guard and the front of the vehicle. During the sequence the sling destroyed the front driver side portion of the vehicle. The suspension sling finally broke when it came in contact with the steel radiator mounting bracket. The front suspension sling also broke. The load was now only suspended by the two left hand suspension slings. Both G-11B parachutes opened fully. The HMMWV landed on the driver side and was heavily damaged.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

At this time the reason for this malfunction is unknown. The suspension slings were correct type and length. They were also new. The vehicle was not overloaded or too light. The extraction parachute and line bag were the correct size and length, no damage was found on the extraction d-bag, line bag or extractin line. The aircraft was inspected by both the riggers and Air Force crew and no damage was found to the aircraft floor or sides.



WHAT WAS THE MALFUNCTION?

Not given.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Suspension sling on the right side was caught on the brush guard, causing them to break and the load came down on its left side.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure that the suspension slings excess is secured tight and properly routed.

I.	•	G	ENERAL					
1. JAIT BE 660 A HUT TEU	A. OEFA CIURE	WHIFTE	יט נ	≜ Ic	# TYPE ACI	:	> AUT SER NO	
	}		- 1		C-130)		
§ OPERATION LEFROISE		7 N7 ANO	TOLYLKIM		# DATE	AND TIME		
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800 Feet	130	32	8 Feet	(5	5 Miles		
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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

The 22-foot extraction parachute deployed and did not fully inflate. The extraction parachute appeared to have a pear shape. The load did not extract. The aircraft made two passes over the DZ. During the third pass (approximately 8-10 minutes from initial deployment), the 22-foot extraction parachute fully inflated and the load extracted. The 22-foot extraction for the sequential load deployed normally and was cutaway since load 2 of 2 had already been restrained by the loadmasters. Load 1 of 2 landed under 2 x G-11Bs on the surveyed DZ although it was inside the tree line. The load landed with no problems.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The initial 22-foot extraction parachute was found in a tree approximately 300 meters from the load. The parachute was recovered and a TRI was performed with results attached. The parachute has been sent to Natick for analysis. Air Force checks of the rails/locks indicated no problems.



WHAT WAS THE MALFUNCTION?

Not given.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

22-foot extraction did not fully inflate. Loadmasters were securing the load in the aircraft when the 22-foot extraction parachute fully inflated and extracted.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Check rigging/packing procedures for 22-foot extraction parachute.

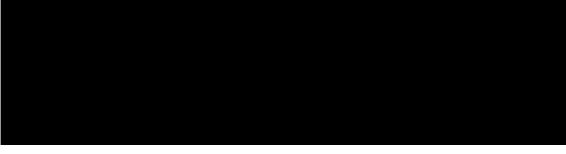
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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

During extraction phase, the platform over came the right hand locks and started to exit the aircraft when the extraction line recoiled back into the aircraft. The platform exited the aircraft and impacted the DZ w/minor damage.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Failure of the type IV connector link caused the extraction line to separate from the EX-chute. Platform had enough momentum to exit the aircraft. Due to no EX-chute, main cargo parachutes did not deploy. Type IV connector was not recovered. Rigging of the extraction system was IAW -9.



WHAT WAS THE MALFUNCTION?

Not given.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Extraction line separated from the extraction parachute due to the type IV connector link.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Check the face plate of type IV link. Do away with type IV.

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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

At approximately 15 seconds prior to the release point, the PDM (parachute deployment mechanism) deployed the drogue parachute. The parachute and drogue elongated and completed a normal inflation. The aircraft continued a normal drop sequence and at 4 seconds prior to release, the drogue parachute collapsed. A malfunction was immediately called and the loadmaster jettisoned the drogue parachute and line. The aircraft landed without further incident.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The drogue parachute collapsed from catastrophic material failure. Four of eight suspension lines on one side of the adapter web broke near the L-link. The remaining suspension lines broke closer to the canopy skirt or had blown or damaged panels. The other side of the adapter web had no broken suspension lines but it did have two damaged panels. This parachute was manufactured in Jan 1985 and placed into service on June 1996 and was on its 27th airdrop. This parachute had repairs at three different times totaling 6.9 hours. The intentional use of this parachute was supposed to be for extraction only and should not have been used as a drogue in this stage of its life cycle.



WHAT WAS THE MALFUNCTION?

Not given.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Drogue parachute collapsed during deployment.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Do not use extraction for drogue.
- 2. Separate the drogue parachutes and count the number of drops on each parachute.

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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

The number 8 left hand lock was engaged in the platform preventing extraction. During the preslowdown checklist, the crew removed the left hand locks. They felt they removed too many locks forward of the platform and decided to re-engage up to lock number seven. When reengaging lock seven, lock 8 inadvertently fell into the platform without them noticing.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Load failed to extract. Loadmaster pulled right hand crossover to the emergency position. Load still failed to extract. Loadmaster initiated emergency procedures and cut extraction line aft of the attachment point. The loadmaster was struck by the 60 foot line recoiling after he cut it causing numerous contusions to the right hand. The extraction parachute and extraction line were recovered 3 miles from the DZ and totally destroyed.



ANALYSIS: 54

WHAT WAS THE MALFUNCTION?

Not given.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Loadmaster did not follow checklist.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure proper procedures are followed.

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WHAT WAS THE MALFUNCTION?

G-12E did not inflate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Parachute not rigged properly.
- 2. Suspension line ties were loose.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- 1. Rig IAW proper TO.
- 2. Ensure proper packing procedures are followed.

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WHAT WAS THE MALFUNCTION?

Hydraulic parachuate release malfunction.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Equipment failure.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Inspect equipment.

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As the CDS exited the aircraft, the crew noticed that one of the G-14s did not fully deploy. This was confirmed by the DZ party. During the bundle's descent, the parachute did inflate and the load landed on the DZ with no damage. 32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)	As the CDS exited the aircraft, the crew noticed that one of the G-14s did not fully deploy. This was confirmed by the DZ party. During the bundle's descent, the parachute did inflate and the load landed on the DZ with no damage. 32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)	A-22	G-14 (2)			\perp		Centerline				
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WHAT WAS THE MALFUNCTION?

G-14 did not fully deploy initially but opened prior to hitting ground.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Air starvation.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Have bundles side by side in the aircraft.

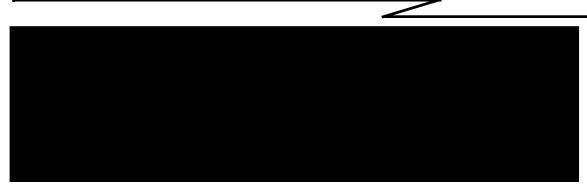
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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

The container exited aircraft normally. Deployment phase appeared normal. No canopy abnormalities were observed. Upon canopy recovery it was noted that the centering line was broken approximately 4 feet 5 inches from apex. Load descended and landed normally. TRI of parachute resulted in light burns the complete length of centering line. Burn hole approximately 4 inches diameter on gore 31 approximately 8 inches up from lower lateral band. No further canopy damage was found. No burns were found on suspension lines or risers. Parachute was packed IAW TM 10-1670-281-23&P.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Could not determine what caused burns on centering line or canopy burn hole. Load exited aircraft at approximately 7200 MSL. Suspect increased opening shock due high altitude drop zone greatly assisted in breaking centering line. Same pass second CDS had zero damage, weight of load was 850 pounds.



WHAT WAS THE MALFUNCTION?

Broken center line.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Possibly bad line.
- 2. Need more information or see parachute to determine exact cause.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Inspect lines closely before packing the parachute.

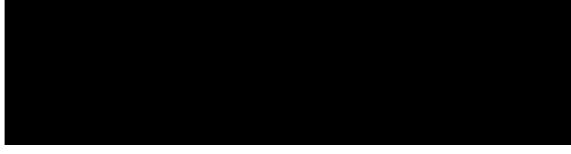
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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

Stinger bundle exited aircraft third in a single stick of 5 center line loaded on C-130. The G-12E failed to elongate resulting in a total malfunction. The stinger bundle was destroyed.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Stinger bundle exited aircraft normally. 68-inch pilot parachute deployed upon G-12E extraction from load. The suspension line stows failed to extract from stow panel. Upon investigating G-12, the last suspension line tie was not tight resulting in the risers slipping through the suspension line tie pulling the second suspension line stow into the first suspension line stow.



ANALYSIS: 59

WHAT WAS THE MALFUNCTION?

G-12E failed to inflate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper packing procedures.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- 1. Perform closer inspection when packing parachutes.
- 2. Rig in accordance with proper rigging manuals.

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the malfunction).

WHAT WAS THE MALFUNCTION?

Bundle stuck in rail (logistic).

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Skidboard was bowed logistic rail latch contacted skidboard.
- 2. Raised screw on latch.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Check skidboards to see if bundle binds.
- 2. Don't drop at least on that side.
- 3. Inspect the skidboard condition by rolling the container in and out of the dual rails.

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ANALYSIS: 61

WHAT WAS THE MALFUNCTION?

Parachute did not deploy.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Improper rigging procedures.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Need more information.

AIRCRAFT MALFUNCTION REPORTS AND ANALYSES

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WHAT WAS THE MALFUNCTION?

Western gear failure.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Could have been weak spring.
- 2. Equipment failure.
- 3. Beaded chain different length.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

 $Ensure\ load master\ follows\ preflight\ procedures/check list.$

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31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

First malfunction: DRAS platforms in L1, L2, and L4 released normally. L3 locks (logistic lock set 6) did not release until L2 slammed into it. Second malfunction: Platform in position R1 released normally but took approximately 30 seconds to exit the aircraft.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Suspected cause of malfunction #1: Logistic locks stalled and did not fully retract from the platform. However, the lock actuator was able to get the lock pawl over center, allowing the force from L2 to push the locks down below platform level. Suspected cause of malfunction #2: The platform was not bowed, however it was loaded in such a manner that it was positioned tight up against the outboard rail. The friction caused by the platform to rail contact significantly reduced the exit speed. Postfight review of the outboard rails revealed a visible scrape mark from the platforms starting position to the aft end of the cargo floor.

CONTINUED ON NEXT PAGE

WHAT WAS THE MALFUNCTION?

Still testing.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Still testing.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Still testing.

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	1]							
	C 12E (1)										
A-22	G-12E(1)	ı		- 1			I F	'S 800			

Eight (four on each side) CDS bundles, weighing a total of 12,000 pounds, were rigged for airdrop with one aft release gate. The gate release mechanism (GRM) was attached to the left number three GRM outlet. Aircraft and bundle rigging/inspection was accomplished IAW current directives. On takeoff roll, the GRM released the aft restraint gate and the bundles rolled aft in the aircraft. The loadmaster informed the pilot of the problem and the takeoff was aborted at approximately 30 knots. Once the aircraft brakes were applied, the forward left and right bundle rolled forward to their original position. The remaining six bundles were wedged in the rails and did not move. There was no damage to the aircraft; however, the aft six container skid boards were destroyed. Although this was not truely an "airdrop" malfunction, this report is being submitted as a tracking document.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The obvious cause of this incident is the fact that the GPM released prematurely. A definite cause for the release has not yet been determined. An investigation into the cause is being conducted through Air Force safety channels and the aircraft contractor.

CONTINUED ON NEXT PAGE

WHAT WAS THE MALFUNCTION?

Gate release mechanism released on takeoff.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Not properly locked (GRM).

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Inspect GRM to ensure properly locked.

l. Confésios a autores	La Cabad	GI NAE ANGIECO	ENERAL JOS	96 14	TYPE AUT	1 S. ACHT SERNO				
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23 TYPELDAD AND 24 NOSED WAY (MICKWAYAIN NO: 45 AR MAL DELIVERY SYSTEM USED										
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Type V	G-12E (2	I .	g Slot			Lock #8				
1. DESCRIPTION OF M	IALEUNCTION/FAI	ILURE/ DAMAGE	INCURRED (if a	nore snace is need	led conti	ille on reverse)				
32. CAUSE OF MAL Number 8 lock fa		_				aircraft.				
	CC	ONTINUED	ON NEXT	PAGE						

WHAT WAS THE MALFUNCTION?

Right hand lock failed.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Equipment failure.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- 1. Increase maintenance checks.
- 2. Ensure proper preflight procedures are followed.

1. GENERAL											
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III CARGO											
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	l					ļ					
A-22	$\int_{G_1}^{G_1}$	2E(1)								617	
11 44	U-12	ъ (1 <i>)</i>	1						1	017	
Aircraft incident. A slack out of cable Timer was good, volume as nd stop winch wa	ped. Main	tenance o	peratio	ns ch	neck	ed the	3 secon	id time	_		
		CONT	INUED	ON NE	EXT	PA	GE				

WHAT WAS THE MALFUNCTION?

Western gear static line retriever failed to run the full cycle and cut the CDS gate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Winch failure.
- 2. Limit switch gap set too close.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Ensure winch is set at the correct gap.
- 2. Reengineer winch design by removing beaded chains and limit switch.

			一							
1.		G	ENERAL							
CONIF BEING A MUITED	2,09944164	IE AIRFIELD		1 0A76			4. TYPE AUT	ŗ	S. ACHT SER NO	
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lli			CARGO							
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	1		DUAL	RAI.	\Box	COSMIL	EASE GATE	DIMEN	(Alegia et	
$ $ $_{\mathrm{CDS}}$	FM 10-500-	-3/	NO PLATE	NO PLATFORMS - NO. CONTAINER			I AIMEMS]	High	
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A-22	26 Fact]					
1	26-Foot									
Container	High V				1			1		

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

Gate failed to cut load failed to exit. The green light came on and the right western gear static line retriever winch ran for approximately 3 seconds. It did not break the 80 lb safety tie. Upon inspection, nothing on the load was found to be in the way or otherwise preventing the knife from cutting. The pulley was rigged at FS 737 with the gate at FS 720. The spring condition on the winch was good and seated in the cup. Both beaded chains were 5 inches in length. When the JAI first looked at the winch after measuring the beaded chains, I saw that the "cup" was not fully seated. The next day after unsealing the aircraft and looking at the winch again with the loadmaster, the "cup" was fully seated. There was no gap on the limit switch. With this information I thought that the limit switch did cut off the winch but, later when I found the "cup" seated, I had no idea what could have happened. No turbulence was encountered. The western gear static line retriever was last inspected on 24 Aug 2000 and overhauled on 6 Aug 1999. No damage occurred.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

After looking at the aircraft and load, the loadmaster determined that it was the western gear static line retriever that slipped when pulling on the cable during the drop. Later when unwound to do a pull test, it tested fine.

CONTINUED ON NEXT PAGE

WHAT WAS THE MALFUNCTION?

Western gear static line retriever failed to operate and cut CDS gate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Cup for spring was out of the slot causing the limit switch to engage.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Ensure proper checklist procedures and take off beaded chains, spring/cup and limit switch off the winch.

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\$ OMAKTION EKTRONE		7 DZ AND LOCATION			A DATI AND FINE				
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III			CARGO		_				
23 TYPELGAD AND WEIGHT	; an in-locate way (mil/tawayain ap : an an an int Detiveny System USP):						;		
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700 Lbs	TO 13C7-1-1	.1	<u> </u>		L	1	·	<u> </u>	
26 THE FLATIONS AND CACH CONTAINER	// TRAE RAMACHUTE AMD MUMBER	78 5 21 6 01 CEASE I	FRACT-ON BE PANACHUTE		19	19 . HNGTH CH BEFFING TIME		30 PON 618	lonof.Gan e Craf
A-22					1				
Container	26-Foot (1)							F	S 410

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

Gate failed to cut. The western gear rewound for 1 1/2 seconds to 2 seconds then stopped. The crew then decided to use the other static line retriever IAW 112C-130, Vol 3, Ch 9. After they had unwound the cable, the crew then decided not to drop due to the amount of time it would have taken to re-rig the pulley (FS 430 side gate cut) and the knife in order to use the right side retriever. After landing I saw that the 80 pound safety tie was unbroken, nothing was catching the knife. When unhooked, the winch ran for 3 seconds. As the winch had already been unwound I could not determine if the limit switch engaged to cut off the winch, later the gap was found to be 1/16 inch. Limit screw was safetied, and the beaded chains were found to be 1/8 inch off (not even). The cup when checked by the JAI was fully seated. The last overhaul date was 15 Aug 00.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Other than saying it was the winch I cannot narrow it down any further.

CONTINUED ON NEXT PAGE

WHAT WAS THE MALFUNCTION?

Western gear failed to cut release gate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Improper operation of winch.
- 2. Beaded chains not even.
- 3. Limit switch gap improper setting.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- 1. Measure chain for proper length.
- 2. Ensure proper preflight procedures are followed.
- 3. Take off beaded chains, spring cup and limit switch.

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		1187455			C-130	AND TIME
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1230 AGL	130 Kilots	1 170		7 15	11015] Chiminica
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WK KHI	ar mosts and minds			44 1141	DELIVERY 545	(€ M (0.24C)
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				1		
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DACH CONTRINER	AND NUMBER	(EASE P	የሐ(ፕላ)ካ #6 ሜቆቃር ኮቴፕሮ	HMC		PISCENT.
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31. DESCRIPTION OF M	IAI EUNOPIONO A TENTO	E/DAMAGE	INCHIDDED (12			
32. CAUSE OF MAI	LFUNCTION/FAILUR Id the anchor arm a	E (If more sp			ŕ	l and fell out
	CON	ΓINUED	ON NEX	T PAGE		

WHAT WAS THE MALFUNCTION?

Aft anchor cable arm and actuator mount broken off.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Metal fatigue or improper usage of arms by not putting them in the correct position for the drop.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Inspect if possible during ISO POC inspection.
- 2. Ensure proper checklist procedures are followed.

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, 0									-		
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650	140	_	590			Calm			7 Miles		
				7							
lli				CARGO							
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				DUAL R	<u></u> Т	CD5 MIL	EASE GATE	ріны	HARRAN		
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1190 LUS	уу Тө <mark>й</mark> баңаСиу		70 5 21 6 0 F 9 36 45 0	PA(T-ON BE	+	1 43 H7&FH . PL	BE4 FING	30.00	NIOHOF.QADI		
DAUP CONTAINER	AND NUMBER		(64% P	AND CHUTE	- 1	iik (413	CDTL.		
	26-Foot R	ing			1						
A-22	Slot (1)							Pı	ılley St 530		
32. CAUSE OF MAI								lon ita	olfwae in		
tact. The stitching		ыгар, п	was not	iced that	me i	i men tuc	urar ny	IOII ILS	en was m		
							-				

WHAT WAS THE MALFUNCTION?

Pulley fell due to material failure.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Old equipment/material.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Change or inspect all straps in fleet.

1.		G	ENERAL					
CONIT BEING A MUITED	2,099#416#1	é Alphieco	1	(34,76	r.	LANE WOLL	S.AGESE	
						C-17		
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800 AGL	145	289)	ı	290m/7			Miles
			7	_				
			CARGO					
	T		7					
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	1		DUA. BA	J. T	COSMILEAS	t LAIE	DIMEN	Asola d
Mass Supply			NO PLATFORM	u.	NO. CONTAC	_		
Load	FM 10-512/			1				
3040 Lbs	TO 13C7-1-8	}	1	_1_				
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		""		1	-			
	1	1	5-Foot	1				
Type V	$G_{-1}(2)$	l R	ing Slot					1 of 1

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

During the release point check 15 seconds prior to the TOT, the right parachute deployment mechanism (PDM) failed to deploy the drogue parachute. The loadmaster activated the PDM backup switch (left side). This action did not release the drogue parachute because the parachute was in the right PDM. The wrong backup switch was activated. The loadmaster initiated the malfunction checklist and the drop was not accomplished. The malfunction checklist was completed immediately, followed by the post drop check.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The right parachute deployment mechanism (PDM) failed to operate during the release point check. The loadmaster failed to activate the right backup drogue parachute switch. The loadmaster activated the left backup drogue parachute switch and nothing happened because there was no parachute in the left PDM.

WHAT WAS THE MALFUNCTION?

Parachute deployment mechanism.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Maintenance found bad actuator and switch.
- 2. Loadmaster failed to follow proper backup procedures.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure soldier activates proper switch.

1.		G	ENERAL					
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570 ft AGL	130 KIAS	2320 F	Ft MSL	13 Knots			10 Miles	
			7_					
III		•	CARGO					
23 TYPELIGAD AND WEIGHT	24 MOSED WAY (MICHAEL)	equalicato:	.,		et Met l	ELIVEHY >* 5	ie w azec	1
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Velocity	TO 13C7-		NO PLATFORM	*	NO. Cah	1414645] ⊦	High
700 LBS	Chapter 9			- 1		l	1	elocity
26 THE FLATIONS AND CAUF CONTRINES	77 TERE PANACHUTE AND NUMBER	78 5 21 6 0 1,64 56	FRACTON BE	19	.⊁Máfn ¢i ∪M í	BEFFING	30.00	LOHOF GARN
				-1				
				1				
A-22	26-Foot (1)	1		- 1			1	FS 700

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

At green light, gate failed to cut. Left side Western Gear Retriever used. The spring condition good. Beaded chain lengths 4 3/4 inches. Cup was seated. Limit switch engaged and cut off the winch. Limit switch screw was safety wired. Limit switch gap 1/8 inch. Pull test not accomplished. Winch rewound about 1 second. 80 lb safety tie did not break. The knife did not catch on the load. The knife was sharp. Pulley installed at FS 737. Gate located FS 700. Non CVR. No turbulence encountered. Western Gear Retriever winch was last inspected by maintenance Aug 99. Retriever winch serial number is 1184R123. Impact of malfunction, user unable to accomplish all proficiency testing. No flight hours lost. No damage incurred.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Cause was determined to be the limit switch screw adjustment. Screw readjustd. Retriever rewound satisfactorily.

WHAT WAS THE MALFUNCTION?

Western Gear Static Line Retriever failed to cut the CDS release gate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Limit switch out of adjustment.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Ensure winches are rigged correctly by maintenance.
- 2. Remove beaded chains, cup, spring, and limit switch.

			<u>Z</u>						
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650 AGL	140	1	590		Caln	n		7 Miles	
			一二						
ĮI		•	CARGO						
S TYPELGAD AND WEIGHT	44 *-0050 W-M-1 [M	DOMANAIN NO :	.,		44 8141	ı bern	/EHY > 151	R M USAC	
			177					•	
		-10/	MG FLAT	MAI. DAMS	Ma. C		16 H S	DIFFE	Area vi
HE/Mass	FM 10-3								
2596 LBS	TO 13C		1						
DAUP CONTRINES	ZZ TRĐĘ PANACHUT AND NUMBEI	F 31 251	ENTRACTON NE NE PANNCHUTE		19 .FM⊗FH TIM¶	C+ 864	FING	30 POA	ТОНОЯ ОДЕЙ М (Раг
		15	Foot Ring						
Type V	G12-E (_						ck #7
	G12 L (2) 1 510	<u>. </u>						
32. CAUSE OF MAI Lock #7 passed in			_	eeded,	continue o	on re	verse.)		
						_			<u> </u>
	CO	ONTINUE	D ON NI	EXT	PAGE				

WHAT WAS THE MALFUNCTION?

- 1. Load failed to extract.
- 2. Emergency right hand crossover actuated to release load.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Increase lock maintenance.
- 2. Lock at tolerance limit.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- 1. Use other locks.
- 2. Increase maintenance inspection and testing.

1											_
1. CONFRENCA NUTED		a, Departure of		NERAL	1 (M)		146	ÞÉ ∆L!T		6 m/sfstus	
CONTRACTOR AND TEST		2.05*********	15-15-00		1 (34)	•		C-13	_	S. ACHT SEM NO	,
4 OMANTON EXTREM			7 DE AND	OCATION			_		NG LINE		_
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922 LBS rigged		O 13C7-1-					1				_
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	26	-Foot				-					
A-22		gh V								550	
31. DESCRIPTION OF M	A LEUNIOT		/DAMAGE	NCUDDE	D ('C			4			
32. CAUSE OF MAI Western Gear Sta off when cable w angle of cable from	atic Line vas draw	Retriever V	Winch, rig	ght side	was	used. Ret	trieve	er acti			
							_				

WHAT WAS THE MALFUNCTION?

Western Gear Static Line Retriever failure and failed to cut CDS gate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Limit switch engaged and shut winch off prematurely.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Ensure maintenance sets switch correctly.
- 2. Remove beaded chains spring/cup and limit switch.

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£.		GE	ENERAL						
CONIF BEING A MUTTED	2,099#410#6	≜IRFIECO		1 (71	.76	- t	TYPE ALIT		S. ACFF SER NO
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\$ ACFT ALTITUDE (Fee)	15 ACFT SP[FD]@nori;	NI DELIEVATO	QH (Feer)	<u>'</u>	a wi	IFACI MMOS (I	Ksaul	13 VISI	MITTE (FeetiMental
800 feet AGL	130 KIAS	1800) Feet	et 350@20				\perp	Unlimited
			- -						
-		-	CARGO	=	_			_	
23 TYPELUAD AND	24 MOSED WAY (MICHAEL)		1		_				
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!]				
1	26-Foot Ring]				
A-22 Contanier	Slot(1)							C/B	@ FS 660

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

The gate failed to cut and the load failed to exit. At "Green Light" the static line retriever winch rewound normally. As the winch cable became taut, the winch stopped rewinding.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

Upon inspection of the western gear static line retriever winch, the spring cup was properly seated and the micro-switch appeared to be functioning properly. However, inspection of the beaded chains revealed that even though they were both between 4 3/4 inches and 5 inches, they were not of equal length. This appears to have led to the micro-switch stopping the winch.

WHAT WAS THE MALFUNCTION?

Western gear static line retriever failed to cut release gate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Loadmaster did not measure beaded chain properly

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

- 1. Measure chain correctly.
- 2. Ensure proper preflight procedures are followed.
- 3. Remove beaded chains, spring/cup and limit switch.
- 4. Remove western gear static line retriever from system.

i.			NERAL				
CONIF BEING A HEIT FED	2. D39##10#6 #	INSTELLO	1,	MTE.	4. TVPE AU		S. ACFF SER NO
OMAATION EKIRGISE		7 07 AND	OCATION		C-1	.30	<u>,</u>
07							
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			7_				
ļi		• •	CARGO				
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				 		1	
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HE Training	FM 10-512						
2875 LBS	TO 13C7-1		l Part Table B4	J9 . HAGEN (s Belling	31. 00	LOHOF.GAD N
CHUP CONTRINER	AND NUMBER	70 5 21 6 0 F (645 6 P	AMACHUTE	iiki(,, ,,,,,,,,	30 AV	(BTL.
				1			
Type V	G-12E(2)		15				650 C/B
32. CAUSE OF MAI	FUNCTION/FAILURE	(If more sp	ace is neede	d, continue o	1 reverse.)		
Right hand locks	#9 and 10 tested IA	AW 33D2	37-9-1, l	ocks releas	sed at 57-	-58 ft.	lbs.
	CONT	INUED	ON NEX	T PAGE			

WHAT WAS THE MALFUNCTION?

Platform failed to extract. Right hand lock emergency crossover actuated to release the load.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Lock could have been at the edge of its tolerance.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

Ensure proper lock maintenance is performed.

1.		G	ENERAL			
CONIT BEING A MUITTED	2.099#416#6	é Alimitéco	1 ,	34. *6	S. ACFT SER NO	
					C-1	17 I
§ OMANDOM EXTREME	•	7 DE AND	LOCATION		& DATI	AND TIME
3 ACFT ALSIMONE (Fee)	15 ACFT SP[FD]@nori;	NI DELIEVATI	QH (Feer)	is soi	FACE WWOS (Escial)	12 VISIBILITY (From Manual
1260	145	289		l	070m/5	5 Miles
			- Z			
III		-	CARGO			
ZE TYPELUAD AND	24 PLOSED WAY FAILURA					
WEKHI			43		we alwn periodeals 242	IE M (ISEC
Mass Supply			DUAL RA	. Т	COSMILEASE DATE	DIREKWARE N
Load	FM 10-512/	,	NO PLATFORM	15	NO. CONTAINENS	1
3050 lbs	TO 13C7-1		,	1		
			1	4		
DAUP CONTRINER	JV TROE PANACHUTE AND NUMBER		Ծավ (T-լ) կ 86 Հայանանի կ TE	1."	. Ma€ra de Beffing Lik ¢	BURCAL OH OF CAR M BURCAL
		,,	.]		
		1	- Foot	1		
Type V	G-12E(2)	l Rir	ng Slot	- 1		1 of 1

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

On the first pass, the first platform exited the aircraft without incident. During the slowdown check on the second pass, the loadmaster tried to arm the Tow Release Mechanism (TRM) and could not get a TRM ARM light. The loadmaster attempted to re-arm the TRM without success. Finally the crew decided to discontinue airdropping and returned to base.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The prox sensors were not properly engaged, which did not allow the TRM ARM light to illuminate. When logic is not satisfactory with the Aerial Delivery System Controller (ADSC) the airdrop cannot be accomplished safely. Maintenance checked the systems and found no defects. They could not duplicate the problem (CND). The aircraft tail number has been noted and will be logged in case the problem continues.

WHAT WAS THE MALFUNCTION?

Tow release mechanism would not arm.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Loadmaster did not install link properly.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Properly seat link in mechanism.
- 2. Install extraction link properly.

1.		G	ENERAL				
S. ONIT BEING A MULTED	2,099#410	≜E +IRFIECO	10	4.76	€, TVPE AU	r	S. ACFF SER NO
					C-13		
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UNK	UNK	UNK	UNK UNK UNK				
			7_				
llı		•	CARGO				
ZI TYPELIDAD AND WEIGHT	44 MOSED WAY (MICE	Manala do :	.,		EMAL DELIVERY SY:	5 FE W USED	:
			DUAL RAIL	П	DS MILEASE GATE	DIMEN	Alebia el
			NO PLATFORM	, n	C. CONTAINENS	٦ .	
UNK	UNK			1			
AG TWPE PERFECUENCES CAUP CONTRINCES	77 TRAE RAMACHUTE AND AUMIRE	70 5 21 6 0 F 9 32 4 9 7	የዉ(ፕላ)ካ ዘር የኢት/መር ዞዬፕሮ	19 . Hr.	GEN DE BELFING E	30 PON 813	. Гонов, фай м Раг
]			
UNK	UNK						
		- I	nicumpup 44				
	MALFUNCTION/FAILU		`	•			,
	 During a personn vrap up then starte 				•		
•	/4-inch cotton wel				L.		
	ht on the knurled o	-			-		_
	4 inch loop at FS						
	Tillen loop at 15		-		ly retrieve th		-

Upon further investigation, found there three things that contributed to the incident. (1) The tie at FS 773 of 1/4 cotton webbing was two turn single instead of one turn double. This made the tie twice as strong. (2) The size of the loop of 1/4-inch cotton webbing was just large enough to fit the quick-disconnect through tightly. This set up the possiblity of catching on the quickdisconnect terminal. (3) The last and final contributing factor is the quick-disconnect terminal itself was made with deeper than normal knurling which made the collar less slippery.

WHAT WAS THE MALFUNCTION?

Wrong rigging procedure by loadmaster.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Loadmaster did not rig properly.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Ensure proper training is given.
- 2. Ensure rigging procedures checklist is followed.

1.		G	ENERAL					
CONIF BEING A MUTTED	2.099#410#6	≜IRFIECO	1 GAZE 0. TYPE AUT			LANE WOLL	S. ACHT SERV	
						C-17		
# OMANTON EKERCISE	•	7 DE AND	LOCATION			& DATE A	NG TIME	
S ACET ALCIPVINE (Fee)	15 ACFT SP[FD]idnori)	NI DELIEVAT	QH (Feer)	13.80	REACE WWOS (rsaul	13 41511	MITTE (FeoriMental
NA	NA	l N	IA	l	NA			NΑ
			- -					
III		-	CARGO					
23 TYPELBAD AND WEIGHT	24 MOGED WAY (MICHAEL)	idhain ah :	.,		at olar fifti	VEHY >>51	e⊌ usec	
Mass Supply			DUAL RA	ı.	COS MILLEAS	t LAIt	рінеч	Alepta et
Load	FM 10-512	/	NO PLATFORM	WY.	NO. CONTAI	4645	1	
3500 LBS	TO 13C7-1		2	1				
46 TAPE PLATITUDE ATT	10 13C/-1		PA(T-0)(-16	٠.		I Euro	31. 000	LOHOF. CALD N
DATE CONTRINES	AND NUMBER		AAAACHUTE]"	IIN(PAT"
		1.5	East]				
T 17		1	Foot					
Type V	G-12 E (2)	ı Kır	ng Slot				I	1 of 2

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

During a local LVAD mission, on taxi out the #19 and 20 right rail airdrop locks disengaged. The loadmaster relocked and armed the locks. This happened several times in flight, platform was secured with tiedown devices and a no-drop decision was made. All events were prior to initiation of airdrop checklists. On investigation the locks only retracted if they were armed. NOTE: At no time did the left rail locks disengage.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

According to the rail shop, the #19 variable restraint lock failed (this is what sets the amount of aft restraint that the lock group is set to). This caused the lock to go to the zero aft restraint setting when armed. This allowed both locks 19 and 20 to release when pressure was applied. The aft lock restraint hydraulically equalized between all locks set in the platform.

WHAT WAS THE MALFUNCTION?

Right lock failed.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Variable restriant lock failed.
- 2. Could not properly set lock.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure lock maintenance procedures are properly followed.

1.		GE	NERAL			
NONIF BEING A MUTTED	2, 099441,46	≜IRFIEUD	J CASE 4, TVPE AI			S. A(FFSERNO
					C-1	41
4 OMANTON EKINGSE	•	7 DE AND 1	OCATION		& DATI	AND TIME
S ACET ALCOHOLDE (E44)	15 ACFT SP[FD (Knort)	NI DELIEVATI	QH (Feer)	n wi	FACE NIMOS (Yeard)	12 VISINITY (From March
550 AGL	150 KCAS	1175	Feet		Calm	7 Miles
			7			
III		•	CARGO			
ZJ TYPELUAD AND	14 PLOSED WAY (MICHAEL)	idhain ah :	i .			
WAS KUN I	FM 10-500	-2/	<u></u>	_	ACUIAL DELIVERY >+:	116 - 4376
	TO 13C7-1	-5	DUAL RAIL		COS MILEASE GATE	DIRENANDA N
LVAD	FM 10-512/	/	NO PLATFORM	١.	Ma. Cah I AIMENS]
3400 LBS	TO 13C7-1		1]		
24 TWPE PERFECUENCES DATE CONTRIVES	// Trate rayaCHUTE AND NUMBER	70.5 21.6 0.7	PACTON BE ANACHUTE		. FMGEN GY BEFFING LIN C	30 PONT OH OF JOAN W
Date Collinated	AND NOTIFE.	(6-24		1		311(82)
				1		
Type V/EFTC	$G_{-1}(2)$	15-Fo	ot Ring Slo	ot		FS 940

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

This was a local training mission consisting of two heavy equipment airdrops. All procedures and checklists were accomplished through the first drop without any problems. The second airdrop was uneventful up through the completion of the slowdown checklist. At "green" light, the extraction parachute deployed normally but the platform failed to exit. The secondary load-master actuated the right hand lock release handle and the platform still failed to exit. The primary loadmaster notified the crew of a malfunction and initiated the malfunction checklist. Both loadmasters proceeded aft to chain down the platform. After the platform was secured and as the primary loadmaster began to cut the extraction line, the extraction parachute collapsed. Shortly thereafter, the extraction line was cut free, with the assistance of the secondary loadmaster. When the secondary loadmaster continued with the checklist by engaging the left hand locks, he noticed that one of the locks was already engaged (rail lock #15). The aircrew completed all remaining checklists and returned to home station without incident. Due to the amount of time it takes to chain a platform down and cut the extraction line, the extraction parachute and line landed approximately 3 miles off the drop zone and reservation. The local tactics flight conducted an off-DZ board.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The obvious cause of this malfunction is that there was a left hand lock engaged in the platform at the release point. The secondary loadmaster, who verified lock retraction during the slowdown checklist, was positive that all locks had been retracted. With this taken into account, the left lock must have "fallen" back into the platform sometime between the completion of the slowdown checklist and the release point. The aircraft was turned over to maintenance and the results of their lock inspection is still pending.

ANALYSIS: 80

WHAT WAS THE MALFUNCTION?

Load did not extract from aircraft.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

- 1. Lock engaged at release point (in platform).
- 2. Left lock fell back in.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Make sure the locks are removed from platform.

1.		GI	ENERAL						
CONIF BEING A MUTTED	2,099441646	≜III51EUÜ		CM.		(, [V)	E WL'I		S. ACHT SEM NO
							C-5		Į.
4 OMANTION EXTREME		7 07 AMD	LOCATION				DATI A	NC TIME	
\$ ACFT ALTITUDE (Fee)	15 ACFT SP[FD]Enori;	11 DELLEVAT	QH (Feer)	13	WIFAC	I MMOS (Ksai	141	13 41511	MITTE (Feet Manual
600 AGL	180 KTS	26	5	l	C	Calm		7	+Miles
			7_						
III		•	CARGO						
23 TYPEDDAD AND WEIGHT	24 FOSED WAY (MICHAEL	idhain an :	.,			· M+L DELIVEN	* >* 3	t ¥ USFC	
Mass Supply			DUAL R	AI.	١,	DS MILLEASE L.	AIE	DIMEN	Alegia et
Load	FM 10-512) /	NO PLATFOR	M\	ħ	0. COM 41464	2		
	TO 13C7-		4	1					
3010 Lbs			<u> </u>		15	. F A. B I F		3	
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		1	5 Foot]					
T X 7	G 10F (2)	- 1	5-Foot						4 of 4
Type V	$\mathbf{I} = \mathbf{G} - 12\mathbf{E}(2)$	ı k	Ring Slot	- 1				I	4 UI 4

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

Malfunction happened on the fourth of four single heavy passes. During preslowdown airdrop checklist, after the loadmaster gave the master control handle a full rotation the rack assembly and arming trigger showed intransit. A no-drop was called and crew returned to home base. The system worked normally during preflight and for the first three drops.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

 $Malfunction\ of\ the\ master\ control\ handle.\ System\ worked\ upon\ post\ drop\ inspection.\ No\ problem\ with\ system\ found\ by\ maintenance.$

WHAT WAS THE MALFUNCTION?

Arming trigger of master control handle failed to arm.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Loadmaster did not fully rotate handle.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure personnel are properly trained on procedures.

1.		GE	NERAL					
NONIF BEING A NUTTED	2.03944164	ME AIRSTEUU	1.0	DA!E		I, TYPE AUT		S. ACFF SER NO
						C-14	41	l
4 OMNATION EXTREME		7 07 AMD	OCATION			& DATI	ANC TIME	
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550 AGL	150 KCAS	1175	Feet	L	Cal	m		7 Miles
			7					
-		•	CARGO					
23 TYPELBAD AND	24 HOSED WAY (MICHOLOGIC	Websit do :	i					
WE KIH I	FM 10-500-	2/	<u>'''</u>	_	44 4141 [FLIAFAA 242	IE M USEC	•
	TO 13C7-1-		DUAL RAI		COSMILI	ASE GATE	DIMEN	Asola d
LVAD	FM 10-512/		NO PLATFORM	"	Ma.Cah	414645]	
3000 LBS	TO 13C7-1-		1 1	1				
46 TWP: PLATIUM AIR	10 13C/-1-	-0 20 521607	RACTON RE	1,9	. Набги сн	BELFING	30,005	LOHOF. GARD N
CHOP CONTAINER	AND NUMBER		ДАЈАСН ЦТЕ	1	HAF	-,	144	PAT"
1				-				
T WEET	C 12E (2)	15 Eas	t Dina Cla	,				EC 000
Type V/EFTC	$\mathbf{I} = \mathbf{G} - 12\mathbf{E}(2)$	1 13-600	t Ring Slo	ιI			1	FS 900

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

This was the second airdrop of this local training sortie. All procedures and checklists were accomplished without incident up to the release point. At "green" light, the pilot not flying activated the parachute release switch and the extraction parachute did not release from the parachute holder (bomb rack). Realizing that the extraction parachute had not deployed, the loadmaster, with some difficulty, activated the extraction parachute manual release handle and the parachute deployed. The platform exited the aircraft without any further incident. Due to the difficulty, the loadmaster experienced with the manual release handle, the platform landed 600 yards long, but was still on the drop zone.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The aircraft was turned over to maintenance, who will determine if a problem exists with the parachute release switch or an electrical problem with the entire release system.

WHAT WAS THE MALFUNCTION?

Extraction parachute deployed properly.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Procedures checking out handle.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Train crew members on proper pulley release handle procedures.

1.		G	ENERAL					
CONIT BEING A MUITED	2.099#416#1	E AIRFIELD	1	(M,*E		4. TYPE AU	r	S. ACFT SER NO
						C-13	0	1
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2670 MSL	130 KIAS	1424	MSL	l	Caln	1		1/2 Mile
			-					
III		•	CARGO					
23 TYPELBAD AND WEIGHT	24 NOSED WAS IMPOSE	Addals An :	۱.,		45 8141	ELIVERY > 1	IE M UZEI	:
	1		⊢—	$\overline{}$	T		1	
	FM 10-500)-3/	DUAL RA	—	COSMIL	EASE GATE	DIMEN	MARKA M
A-22 CDS	TO 13C7-1	1-11	NO PLATFORM	" [Ma.Cah	I 414EHS		High
1600 LBS	Chapter 8				2			Velocity
JA 1975 PLATITURE AIR CAUP CONTRINES	77 TRAL PANACHUTE AND NUMBER		PACTON BE	19	i .⊧Máľu ¢i ijMiľ	BE4 FING	30 PO 6/3	. Гоноборал м Сваг
				1	-			_
	26-Foot			1				
48 X 48 X 3/4	High V(1)						1	

31. DESCRIPTION OF MALFUNCTION/FAILURE/ DAMAGE INCURRED (if more space is needed, continue on reverse.)

The loadmaster on the airplane stated that at "green light", the western gear static line retriever winch on the right side of the aircraft started to rewind and shut off after one second. The winch stopped rewinding prior to breaking the 80 pound safety tie on the guillotine knife. The Type XXVI nylon release gate was never cut, and the bundles remained in the aircraft. No turbulence was encountered by the aircrew during the time of the malfunction. There was no damage to the bundles or aircraft.

32. CAUSE OF MALFUNCTION/FAILURE (If more space is needed, continue on reverse.)

The right hand retriever comperssion spring was in good condition with the cup fully seated, the beaded chains were measured and found to be symmetrical at 4 3/4 inches. The current limit switch was engaged with the limit switch screw safety wired. A pull test was conducted by maintenance and found to be within limits. The serial number and NSN of the retriever was unattainable due to the retriever having been freshly painted to include the data plate. The center of balance for the CDS was at FS 552. The gate was rigged at FS 600 and the pulley was rigged at FS 617. Maintenance discovered a wire intermittently shorting out in the airdrop troop jumplight on the copilot's jump control panel. The malfunction was attibuted to the electrical short. Due to the malfunction, two loadmasters lost currency on a CDS drop.

WHAT WAS THE MALFUNCTION?

Western Gear Static Line retriever cut off prematurely failing to cut the CDS gate.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Electrical short.

WHAT SHOULD YOU DO TO KEEP THIS FROM HAPPENING?

None.

							_
1.			NERAL			• • • • • • • • • • • • • • • • • • • •	
CONIT BEING A BUILTED	2,099#476#6	≜IMFIECO	1 (74	,7E C	C 120		b
		1		<u> </u>	C-130		_
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			-				
III		•	CARGO				_
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M. Mill			\vdash	 	-		_
			HO PLATFORMS	NO. CONTLEAS		DINEN WARFA	
CDS	FM 10-500-3		""	10.00	41.12		
922 Rigged	TO 13C7-1-1			1		High Velocity	
26 THE PLATFORM AND CHOICE CONTRINER	// Trat raya(HUTt	78 5 21 6 8 F (6456 F	የዱ(ፕላ)ካ ዘር ሜዲያርት _ካ ቸር	JA . PROTEIN CHIE	4 FING	BU PONT OH OF LOAD BRICKET	•
]			
A 22	26 F 4 HV (1)					FS 530	
A-22	26-Foot HV (1))]		1		TS 550	_
	at green light. Retu release gate. Safe						
	her errors encount						
32. CAUSE OF MAL	FUNCTION/FAILURE	(If more sp	ace is needed,	continue on re	verse.)		
		ì			ŕ		
Dull knife							
	CON	ΓINUED	ON NEXT	PAGE			

WHAT WAS THE MALFUNCTION?

- 1. Knife failed to cut gate.
- 2. CDS gate failed to cut.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Dull knife.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

Ensure knife is properly inspected prior to use.

١.			GE	NERAL						
CONIT BEING A MUTTED	\neg	2. D 34#411,46 4	INFIELD		1 (24.6		Τ,	TYPE AU		S. ACFF SEM NO
							┸	C-13	30	1
OMARIOM ERCHOLIS			7 DT AND	OCATION				& DATI	ANC TIME	·
								l		
ACFT ALSIPVINE IF441	IS ACETSPIC	Dijenori)	11 DELLEVATI	QH (Feer)	13.9	UBFACE	MMOS ;	Ksaul	12 415	MITTE (Freed Marcal
1200	1,	40 !	47	2	1		6-8		1	Unlimited
		10								
			-							
III Za pypelijao ang	Ja Lisansi	www.fantichaa		CARGO L						
WENT	14		v-1- 40.			461	ıı+ı beı	IVEHY SA	re⊯ use	;
	l			DUA. P		60	SHLLEA	5E 6#1E	DIME	Magain
	l			HO PLATED	_		Canta		٠	
HE Training	FM	1 10-512/								
2875 LBS	TC	13C7-1	-8	1	1_					
26 TWPE PERFECUENCES DRUP CONTRINES	37 Trak rai AMD AU	ų≜(HUTE I ME EI	70 5 21 6 0 F 9 32 4 30 1	PA(T-() ly 86 AdjaCpt_TE	١,	9 . F#6 9 ALL	Ги Сь Пе	4 FING	30 90	стоноя. фал м Свагт
					- 1					
	l				- 1					
Type V	G-1	2E(2)]	15-Foot					1	630
Extraction parace loadmaster place setting 2.50. No setting 2.50 and Right lock #9 te	ed right ha damage o LFUNCTIO	nd contro r training N/FAILURE	l handle to lost.	o the EM	ERG	ENC ontinu	Y po	sition	. Right	

WHAT WAS THE MALFUNCTION?

- 1. Load failed to extract.
- 2. Actuated right handle lock emergency crossover to release load.

WHAT COULD HAVE CAUSED THIS TO HAPPEN?

Faulty locks.

WHAT SHOULD YOU DO TO KEEPTHIS FROM HAPPENING?

- 1. Rotate lock.
- 2. Have maintenance check out.

SUMMARY OF SUPPLY AND EQUIPMENT DROPS

3ND TRIANNUAL CY 2000

		FORM OAD		GLE AINER	C	DS	TO	TAL
Number of Drops	11	99	1	71	1.	359	27	29
Number of Malfunctions		8		0		7		15
Percentage of Malfunctions	0.	67		0	0	.52	0.	55
Malfunction Phases:	IP	EF	IP	EF	IP	EF	IP	EF
Extraction	2	3	0	0	2	1	4	4
Deployment-Recovery	1	0	0	0	1	3	2	3
Release	0	2	0	0	0	0	0	2

IP-Incorrect Procedures

EF-Equipment Failure

SUMMARY OF PERSONNEL PARACHUTE JUMPS

3RD TRIANNUAL CY 2000

		C-17	C-130	C-141	OTHER	TOTAL
	Number of Deployments	11,264	31,199	10,235	1,167	53,865
Nonmaneuverable	Number of Malfunctions	0	2	0	1	3
	Percentage of Malfunctions	0.0	0.006	0.0	0.086	0.006
	Number of Deployments	329	3,108	779	4,802	9,018
Maneuverable	Number of Malfunctions	0	1	0	0	1
	Percentage of Malfunctions	0.0	0.032	0.0	0.0	0.011
	Number of Deployments	275	3,184	39	2,101	5,599
Free-Fall	Number of Malfunctions	1	13	0	8	22
	Percentage of Malfunctions	0.36	0.40	0.0	0.38	0.39
	Number of Deployments	11,868	37,491	11,053	8,070	68,482
Total	Number of Malfunctions	1	16	0	9	26
	Percentage of Malfunctions	0.008	0.042	0.0	0.11	0.038

SUMMARY OF PERSONNELPARACHUTE MALFUNCTIONS

3RD TRIANNUAL CY 2000

	NON- MANEUVERABLE	MANEUVERABLE	FREE-FALL	RESERVE
Number of Deployments	53,865	9,018	5,599	0
Number of Malfunctions	3	1	22	0
Towed Jumper	0	0	0	0
Broken Static Line	0	0	0	0
Entanglement	0	0	1	0
Failed to Inflate	0	0	0	0
Inversion	0	0	0	0
Pilot Chute	0	0	4	0
Semi-inversion	0	0	0	0
Suspension Lines	1	1	7	0
Other	2	1	10	0
Percentage of Malfunctions	0.006	0.011	0.39	0.00
Fatalities	0	0	0	0

^{*}Injuries

INJURIES OCCURRING ON PARACHUTE OPERATIONS AS REPORTED ON DA FORM 285

1 JULY - 30 SEPTEMBER 2000

	C-17	C-130	C-141	UNKNOWN	TOTAL
PLF-Related Injuries	13	9	1	35	58
Main Malfunction	0	0	0	0	0
Misrouting of Static Line	1	0	0	5	6
Entanglements	3	1	0	1	5
Tree Landings	0	0	0	2	2
In Aircraft	0	0	0	0	0
Hazards on Drop Zone	0	1	0	2	3
Other	2	3	0	12	17
Insufficient Information	0	0	0	1	1

AIRCRAFT MALFUNCTIONS

These malfunction reports are not included in the statistical data nor reflected in the percentage of malfunctions. All aircraft systems malfunctions which may have led to an abort or no-drop are constantly reviewed and analyzed for repeat or recurring trends and solutions. Corrective actions are recommended through Air Force maintenance systems.

PERSONNEL DROPS	
Improperly operating doors or ramps	0
Static line retriever	2
SUPPLY AND EQUIPMENT DROPS	
Rail locks	8
Improperly operating ADS	1
Improperly operating doors or ramps	0
Release mechanism	3
Electrical system	1
CONTAINER DROPS	
Rollers	0
Type XXVI gate	1
Static line retriever	9
Release Mechanism	1
TOTAL	26

HOT POOP

The following messages were sent out during this quarter.

Message dated RU 201313Z Mar 01:

SUBJECT: New Requirement - Continuous Riser Extensions for G-11 Cargo Parachutes.

- 1. This memorandum is published as an ADVANCE NOTICE TO THE FIELD to allow ample lead time to procure sufficient stocks of Continuous Riser Extensions for G-11 Cargo Parachutes.
- 2. The US Army Airborne and Special Operations Test Directorate and the US Army Soldier Systems Center (Natick) have established that all G-11 cargo parachute riser extensions will be of continuous length. The requirements will be as follows:
 - Two parachute loads must have 20-foot (2-loop), type XXVI nylon slings.
 - Three and four parachute loads must have 60-foot (3-loop), type XXVI nylon slings.
 - Five through eight parachute loads must have 120-foot (2-loop), type XXVI nylon slings.
- 3. This new requirement becomes effective with the release of the revision to FM 10-500-2, Rigging Airdrop Platforms. The projected release date is first quarter FY 02.
- 4. POC for this action is CW5 Waldo, commercial (804-734-3178) or DSN 687-3178.

Memorandum dated 15 Feb 2001.

SUBJECT: Interim Authorization to Use 3 3/4-inch, Two-Point Link Assembly in Place of Type IV Link Assembly

- 1. Interim authorization is granted to use the 3 3/4-inch, two-point link assembly in place of Type IV link assembly to attach the extraction line to the 15-foot extraction parachute or drogue parachute.
- 2. Attach the two-point link assembly to the 15-foot extraction parachute or drogue parachute and the 60-foot (1-loop) extraction line as shown in FM 10-500-2/TO 13C7-1-5, page 3-147, Figure 3-122 using steps 1 and 2.
- 3. Secure the two-point link assembly to the 15-foot extraction parachute or drogue parachute as shown in FM 10-500-2/TO 13C7-1-5, page 3-150, Figure 3-123 using steps 8 and 10.
- 4. Recommend the two-point link assembly be considered the primary item of use and the type IV link assembly considered the substitute item.
- 5. This authorization has been approved by:
 - a. Mr. Moorachian, USA SBCCOM(N)
 - b. Mr. Leger, USAF, ASC
 - c. MSgt Wagner, USAF, AMC
- 6. POC for this action is CW5 Waldo, DSN 687-3178 or Roger Hale, DSN 687-4769.

HOT POOP (Continued)

Message dated 04/05/2001

SUBJECT: Securing the T-10 Modified Parachute, Corrected copy 04/05/2001

Please replace the original copy of this message with the corrected one as follows:

- 1. Secure the T-10 modified parachute to a door bundle as shown on Page 3-18, Figure 3-7 of FM 10-500-3/TO 13C7-1-11/FMFM 7-47, Rigging Containers.
- 2. This change supercedes the procedures for securing the T-10 modified parachute shown on Page 3-24, Figure 3-8 of C1, FM 10-500-3/TO 13C7-1-11/FMFM 7-47.
- 3. This change in procedures will be included in the next change/revision to the field manual.
- 4. Air Force Technical Order (TO) users are authorized a temporary pen and ink change in the current Technical Order until a revision or change is fielded.
- 5. The point of contact for this action is CW5 Waldo, DSN 687-3178 or commercial (804) 734-3178.

Message dated Oct 00

SUBJECT: Corrected Copy of Message 311313Z Oct 00, Change to FM 10-500-3/TO 13C7-1-11, Change 1, dated 26 September 1996.

- 1. Chapter 2, page 2-2, paragraph 2-2A, Paratroop Door Loads. Delete the fifth sentence completely and replace with the following three sentences:
- 2. Loads that will be followed immediately by parachutists will be rigged with cargo parachutes having nonbreakaway static lines. Each static line must have a drogue attached to it as outlined in the technical manuals. When using the T-10 cargo parachute or 68-inch pilot parachute for the paratroop door load, the deployment bag serves as the drogue.
- 3. The point of contact for this action is CW5 Waldo, DSN 687-3178 or commercial (804) 734-3178 or MSgt Al Wagner, DSN 687-4757 or commercial (804) 734-4757.